

THE DIVISION OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

59-018871

STATE FILE NUMBER

FILED MAY 26 1959

Registration District No. 316 Primary Registration District No.

Registrar's No. 200

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>St. Francois</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Francois</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Francois Township</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>Bismarck</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>State Hospital #4, 23y; 11M; 21das.</b>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <b>23y; 11M; 21das.</b>
3. NAME OF DECEASED (Type or print) First Middle Last <b>IRVING VERNOR BLANTON</b>		4. DATE OF DEATH Month Day Year <b>May 9, 1959</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 5, 1918</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		9b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. <b>40</b> Months <b>9</b> Days <b>4</b> Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Bismarck, Missouri</b>
13a. FATHER'S NAME <b>James Carter Blanton</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Eva Wallen</b>	14. NAME OF HUSBAND OR WIFE <b>##</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	17. INFORMANT Address <b>Mrs. Eva Blanton, Bismarck Mo.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Status Epilepticus - - - - - instantaneous.</b> DUE TO (b) <b>Convulsive Disorders (epilepsy) - - - - - Abt. 33 yrs.</b> DUE TO (c) <b>3532</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Psychosis with convulsive disorders (epilepsy), epileptic deterioration,</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from <b>May 9, 1959</b> to <b>May 9, 1959</b> and last saw him drive on <b>May 9, 1959</b> Death occurred at <b>7.45 A.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>John C. Brennan M.D.</b>		22b. ADDRESS <b>State Hospital No. 4 Farmington, Missouri</b>	22c. DATE SIGNED <b>5-9-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
<b>burial</b>	<b>5-11-59</b>	<b>Woodlawn Cemetery</b>	<b>Leadington Mo.</b>
24. FUNERAL DIRECTOR (Name and address) <b>White Funeral Home, Bismarck Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>May 20, 1959</b>	26. REGISTRAR'S SIGNATURE <b>Ether Rudloff</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

OCT 6 1959

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed *Quel White* .....

Licensed Embalmer No. *2012* .....

P. O. Address *Imator, Mo.* .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.