

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-029631

STATE FILE NUMBER

FILED VS AUG 20 1959

Registration District No. 174 Primary Registration District No. 3035 Registrar's No. 66

S. 300
v. 1-57

1. PLACE OF DEATH a. COUNTY <u>Lafayette</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lafayette</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Lexington</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Higginsville</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Memorial Hospital</u>		Length of stay in lb <u>15 Days</u>	d. STREET ADDRESS (If outside, give location) <u>202 West 21st</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Ora</u> Middle <u>Griffin</u> Last <u>Blake</u>			4. DATE OF DEATH Month <u>February</u> Day <u>21</u> Year <u>1959</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 2, 1880</u>	9. AGE (In years lost by day) Years <u>78</u> Months <u>4</u> Days <u>19</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR OCCUPATION <u>Home</u>	11. BIRTHPLACE (City and state or country) <u>Randolph Co. Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>J. G. Griffin</u>		13b. MOTHER'S MAIDEN NAME <u>Dathulia Lyle</u>		14. NAME OF HUSBAND OR WIFE <u>Perry D. Blake Dec.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT Address <u>Mrs. R. N. Framton Higginsville, Mo.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Ventricle</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 Years</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					
DUE TO (b) _____					
DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) <u>151X</u>					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 _____ a.m. _____ p.m.					
20d. INJURY OCCURRED WHILE AT WORK <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 <u>Dec. 13, 1951 - 2-20-59</u> and last saw her alive on <u>Feb 20-1959</u> Death occurred at <u>10: AM</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>W. Koppensund</u>		(Degree or title)		22b. ADDRESS <u>Higginsville Mo</u>	
22c. DATE SIGNED <u>Feb 23-59</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>2-23-1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Clifton Hill</u>	
23d. LOCATION (City, town, or county) <u>Clifton Hill, Mo.</u>					
24. FUNERAL DIRECTOR <u>F. A. Hoefler</u>		ADDRESS <u>Higginsville, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>2-25-59</u>	
26. REGISTRAR'S SIGNATURE <u>[Signature]</u>					

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.

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 *Forrest R. Hoefler*

480I
Licensed Embalmer No.....
P. O. Address *Higginsville, 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.