OURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS JAN – 6 1960 73

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STATE FILE NUMBER

AMENDED

Registration District No. 73 Primary Registration District No. 5291 Registrar's No. 1

1. PLACE OF DEATH
a. COUNTY: Clay
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Liberty — Length of stay in 1b: 1 day
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: I.O.O.F. Hospital — Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo. b. COUNTY: Clay
c. CITY OR TOWN: Gladstone — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 1202 E 67 Place No KC-18 Mo. — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: IdA Middle: MAe Last: Blodgett

4. DATE OF DEATH: Month: Dec Day: 26 Year: 59

5. SEX: Female
6. COLOR OR RACE: white
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 5-11-1866
9. AGE (last birthday): 93
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HR: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home maker
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): St Jo. Ind.
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: WM Nelson
13b. MOTHER'S MAIDEN NAME: Melinda
14. NAME OF HUSBAND OR WIFE: Chester Blodgett

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Mrs. Edith Strete Address: of Home

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 3 wks.
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 (a)
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ **SUICIDE** ☐ **HOMICIDE** ☐
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. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 July 1959 to Dec. 26, 1959 and last saw her alive on Dec. 26, 1959
Death occurred at 1130 p m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): E. J. Peterson, MD.
22b. ADDRESS: 6708 N. Oak, K.C. 18, Mo.
22c. DATE SIGNED: 12-27-59

23a. BURIAL, CREMATION, REMOVAL (Specify): removal
23b. DATE: Dec 27-59
23c. NAME OF CEMETERY OR CREMATORY: Forest Home Cem.
23d. LOCATION (City, town, or county) (State): Hicksville Ohio.

24. FUNERAL DIRECTOR ADDRESS: D.W. Neumann Sons
25. DATE RECD. BY LOCAL REG.: 12-27-59
26. REGISTRAR'S SIGNATURE: Mabel Graham

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT — MEDICAL CERTIFICATION — BY AFFIDAVIT OF

DR. Pleasen

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 John V. Henrick, Jr.

Licensed Embalmer No. 4848

P. O. Address K. B. 17, Ind

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp 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.