

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59045075 5904507
STATE FILE NUMBER
3056 Registrar's No. 279

FILED VS DEC 30 1959

Registration District No. 294 Primary Registration District No. 3056 Registrar's No. 279

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Additional information
Rate of information

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms with or without. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Randolph | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY BOONE | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Moberly | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN Sturgeon Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Community Hospital | | Length of stay in 1b 9 hours | d. STREET ADDRESS (If outside, give location) ----- Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last KATIE BELLE BLAKEMORE | | | 4. DATE OF DEATH Month Day Year Dec. 4 1959 |
| 5. SEX Female | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Nov. 20, 1874 |
| 9. AGE (In years last birthday) 85 | IF UNDER 1 YEAR Months Days 0 14 | IF UNDER 24 HRS. Hours Min. ----- | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker | | 10b. KIND OF BUSINESS OR INDUSTRY Home | 11. BIRTHPLACE (City and state or country) Lafayette Co., Mo. |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13a. FATHER'S NAME William F. Wolfenbarger | 13b. MOTHER'S MAIDEN NAME Cynthiana Frakes |
| 14. NAME OF HUSBAND OR WIFE Shelton D. Blakemore | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No None | 16. SOCIAL SECURITY NO. None |
| 17. INFORMANT Mrs. Louis Swavze, 2636 E. 34th | | Address Tulsa, Okla. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Medullary Failure | | | INTERVAL BETWEEN ONSET AND DEATH 4 hrs. |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Anesthetic gases + Toxemia | | | 1 hr |
| DUE TO (c) Strangulation of Rt femoral Hernia | | | 1 day |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 5611 | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 July 1959 to Dec 4, 1959 and last saw <u>her</u> alive on Dec 4 1959 Death occurred at 8:31 P m on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) Henry J. Stewart D.O. 2 | | 22b. ADDRESS Sturgeon, Mo | 22c. DATE SIGNED 12-4-59 |
| 23a. BURIAL, CREMATION REMOVAL (Specify) Burial | 23b. DATE Dec. 6, 1959 | 23c. NAME OF CEMETERY OR CREMATORY Mt. Horeb Cemetery | 23d. LOCATION (City, town, or county) (State) Sturgeon, Missouri |
| 24. EMBALMER'S NAME AND ADDRESS Dr. C. M. Sturgeon, Moberly, Mo | | 25. DATE RECD. BY LOCAL REG. 12-6-59 | REGISTRAR'S SIGNATURE Leah Blakemore |

(Licensed Embalmer's Statement on Reverse Side)

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 *Bill J. Meador*

Licensed Embalmer No. *4876*
P. O. Address *Sturgeon, Minn*

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.