

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-024013

STATE FILE NUMBER

Registration District No. 233 Primary Registration District No. 4346 Registrar's No. 105

DO NOT WRITE ON THIS STUB

AMENDED

FILED Jul 10 1962

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Montgomery</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Montgomery City Mo</u>		Length of stay in 1b <u>life</u>	c. CITY OR TOWN <u>Montgomery City Mo</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>Home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Home</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Millie</u> Middle <u>XXX</u> Last <u>Bledsoe</u>			4. DATE OF DEATH Month <u>June</u> Day <u>3rd</u> Year <u>1962</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</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>3-23-74</u>
9. AGE (last birthday) <u>88</u>		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) <u>home</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Montgomery City Mo</u>
13a. FATHER'S NAME <u>Unknown</u>		13b. MOTHER'S MAIDEN NAME <u>Ester Duncan</u>	14. NAME OF HUSBAND OR WIFE <u>Sam Bledsoe "Dead"</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>no</u>	17. INFORMANT <u>Mrs Julia Herington Montgomery Mo</u> Address _____
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>Coronary Occlusion (Thrombosis)</u> <u>Bronchial Asthma</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Pulmonary Emphysema</u> DUE TO (c) <u>Cardio-renal Disease</u> <u>Generalized Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>25 yrs</u> <u>25 yrs</u> <u>5 yrs</u> <u>5 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Chronic Nephritis and ascites and edema</u>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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. Month, Day, Year _____		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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. 4, '39</u> to <u>Jan. 3, '62</u> and last saw her/him alive on <u>6-1-62</u> Death occurred at <u>8:30 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated. <u>E. J. T. ANDERSEN, M. D.</u>			
22a. SIGNATURE (Degree or title) <u>E. J. T. Andersen, M.D.</u>		22b. ADDRESS <u>MONTGOMERY CITY, MO.</u> <u>Montgomery City, Mo.</u>	22c. DATE SIGNED <u>6-5-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>6-8-62</u>	23c. NAME OF CEMETERY <u>Montgomery City</u>	23d. LOCATION (City, town, or county) (State) <u>Montgomery City Mo</u>
24. FUNERAL DIRECTOR <u>C. Whitkins</u>		ADDRESS <u>Montgomery City Mo</u>	25. DATE RECD. BY LOCAL REG. <u>6-5-62</u> 26. REGISTRAR'S SIGNATURE <u>Laure B. Callaway</u>

USE BLACK INK OR TYPEWRITER RIBBON

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,
~~on~~ on the 3 rd day of June 1962, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____

C. W. Hopkins
C. W. Hopkins
C. W. Hopkins

Licensed Embalmer No. I 487

Montgomery City Mo

P.O. Address

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.