

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-031812

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 1493
FILED AUG 26 1963

Primary Registration District No. 5381

Registrar's No. 76

VS 300
Rev. 4/59

10330

20330

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9331X

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12900

13 1-0

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY DENT		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY DENT	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN CURRENT TOWNSHIP		Length of stay in 1b 15 YRS.	c. CITY OR TOWN RURAL
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION RESIDENCE		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) ROUTE 5 SALEM, MO.
3. NAME OF DECEASED (Type or print) First Middle Last ALLEN -- BLEVINS SR.		4. DATE OF DEATH Month Day Year AUGUST 17 1963	
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1/23/1859
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY AGRICULTURE	11. BIRTHPLACE (City and state or country) BENTON CO. ARK.
13a. FATHER'S NAME MICHAEL R. BLEVINS		13b. MOTHER'S MAIDEN NAME ELIZABETH WAKEFIELD	14. NAME OF HUSBAND OR WIFE GENOA (DECD)
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO --		16. SOCIAL SECURITY NO. NONE	17. INFORMANT MIKE BLEVINS ROUTE 5 SALEM, MO.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MALNUTRITION + Dehydration DUE TO (b) CEREBROVASCULAR ACCIDENT DUE TO (c) Cerebral + Generalized Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) ADVANCED AGE!			INTERVAL BETWEEN ONSET AND DEATH 1wk 10 days
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 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 1955 to 1963 and last saw her alive on August 15, 1963 Death occurred at 5:00 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE B. J. Bass, MD		22b. ADDRESS Salem, Mo	22c. DATE SIGNED 8/17/63
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 8/19/1963	23c. NAME OF CEMETERY OR CREMATORY CEDAR GROVE	23d. LOCATION (City, town, or county) SALEM, MO.
24. FUNERAL DIRECTOR WARFEL, MAX L.		25. DATE RECD. BY LOCAL REG. 8-19-63	26. REGISTRAR'S SIGNATURE M. M. Hart, MD by AM

(Licensed Embalmer's Statement on Reverse Side)

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,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Edward F. Broyles

Licensed Embalmer No. 4553

P. O. Address Bx-125 Salem Missouri

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.