

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

SEP 6 1939 399

Registration District No. _____

Primary Registration District No. 1002

Registrar's No. **3347**

1. PLACE OF DEATH:
 (a) County Jackson
 (b) City or town Hannas city
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: H. C. Gen Hosp
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 6 days
 (Specify whether
 In this community _____
 years, months or days)

3. (a) PRINT FULL NAME Clayton Blanchard
 3. (b) If veteran, name war No.
 3. (c) Social Security No. No.

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M
 6. (b) Name of husband or wife Anna Blanchard (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased No 17 1873
 (Month) (Day) (Year)

8. AGE: Years 65 Months 9 Days 7 If less than one day _____ hr. _____ min.

9. Birthplace Union
 (City, town, or county) (State or foreign country)

10. Usual occupation none

11. Industry or business _____

MOTHER FATHER
 { 12. Name unknown
 { 18. Birthplace unknown
 { 14. Maiden name _____
 { 15. Birthplace unknown
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Record Clerk
 (b) Address H. C. Gen Hosp

17. (a) Burial (b) Date thereof _____
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Floral Hills

18. (a) Signature of funeral director J. W. Wagner
 (b) Address Hannas City MO

19. (a) 9/25/39 (b) M. M. Brown
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State MO (b) County Jackson
 (c) City or town Hannas City
 (If outside city or town limits, write "RURAL")
 (d) Street No. 922 Jefferson
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 24
 year 1939 hour 12 minute 55 1/2 M.

21. I hereby certify that I attended the deceased from Aug 18
18 1939 to Aug 24 1939
 and that death occurred on the date and hour stated above.

Immediate cause of death cerebral hemorrhage of right frontal lobe Duration: _____

Due to Idiopathic hypertension and arteriosclerosis

Due to etc

Other conditions _____
 (Includes pregnancy within 3 months of death)

Major findings:
 Of operations _____

Of autopsy _____

PHYSICIAN

 Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____
 (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
 Means of injury _____

23. Signature P. F. De Marco MD (M.D. or other)
 Add Supt H. C. Gen Hosp Date signed 9/25/39

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed

A. R. Hauschild

Licensed Embalmer No.

4062

P. O. Address

K. C. 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 this body is not embalmed, above space should be left blank.