

MAILED MAY 13 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

13954

State File No. _____

Registration District No. **85**

Primary Registration District No. **1001**

Registrar's No. **433**

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
605 N. 11th.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

In this community 55 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Buchanan

(c) City or town St. Joseph
(If outside city or town limits, write "RURAL")

(d) Street No. 1313 N. 10th.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME ROBERT WILLIAM BLYTHE

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex male 5. Color or race white

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Anna Blythe

6. (c) Age of husband or wife if alive 78 years

7. Birth date of deceased July 10th. 1859
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>81</u>	<u>9</u>	<u>7</u>	hr. _____ min. _____

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

10. Usual occupation Retired

11. Industry or business Printer

MOTHER FATHER

12. Name Geo. Blythe

13. Birthplace unknown Ireland
(City, town, or county) (State or foreign country)

14. Maiden name Mary Ann Parr

15. Birthplace Charleston SO. Caroli
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. M.B. Wiedman

(b) Address 1313 N. 10th St. Joseph, Mo.

17. (a) Burial (b) Date thereof 4-19-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director FLEEMAN & SON INC.

(b) Address St. Joseph, Mo.

19. (a) Apr 19, 1941 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 17th.
year 1941 hour 6 minute 09 A. M.

21. I hereby certify that I attended the deceased from April 16, 1941, to April 17, 1941; that I last saw him alive on April 16, 1941 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage (Second stroke)

Due to _____

Due to _____

Other conditions gsw
(Include pregnancy within 3 months of death)

Major findings:
Of operations None

Of autopsy None

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? _____

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

23. Signature [Signature] (M. D. or other) [Signature]
Address 302 Baublinger Bldg. Date signed 4-17-41

Duration This attack 24 hrs.

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 _____

Carl W. Hause

Licensed Embalmer No. _____

3953

P. O. Address _____

St. Joseph, 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, fact should be so stated above.