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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

32768

State File No.

Registration District No. 139

Primary Registration District No. 6101

Registrar's No.

1. PLACE OF DEATH:

(a) County Stoddard  
(b) City or town Rural (If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME Maggie Teachenor Blunt

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Sylvester Blunt 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Dec. 2 1887  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
53 9 24 \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name George Teachenor

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

14. Maiden name Julia Combs

15. Birthplace Illinois  
(City, town, or county) (State or foreign country)

16. (a) Informant Sylvester Blunt  
(b) Address Essex, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/28/41  
(Month) (Day) (Year)  
(c) Place: burial or cremation Taylor Cem.

18. (a) Signature of funeral director Blankenship-Strickland  
(b) Address Dexter, Mo.

19. (a) \_\_\_\_\_ (Date received local registrar) (b) 754 (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Stoddard  
(c) City or town Rural (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 26  
year 1941 hour 9 minute 45 AM.

21. I hereby certify that I attended the deceased from 9-24  
1941 to 9-26, 1941  
that I last saw him alive on 9-26, 1941,  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Due to Paralysis

Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include 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) (f) Means of injury \_\_\_\_\_

23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
Address [Signature] Date signed 9/28/41

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

OCT 14 1949

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 *J. J. [Signature]*  
Licensed Embalmer No. 3479  
P. O. Address *[Signature]*

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.

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STANDARD CERTIFICATE OF DEATH

State File No. 32768

Registration District No. 839

Primary Registration District No. 6101

Registrar's No.

1. PLACE OF DEATH: Stoddard  
 (a) County.....  
 (b) City or town..... Rural  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution.....  
 In this community.....  
 years, months or days)

3. (a) PRINT FULL NAME Maggie D. Blunt  
 3. (b) If veteran, name war.....  
 3. (c) Social Security No.....

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive about 6 years

7. Birth date of deceased Dec 2 1887  
 (Month) (Day) (Year)

8. AGE: Years 53 Months 9 Days 14 (If less than one day) min.

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

10. Usual occupation.....

11. Industry of business.....

12. Name.....

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

14. Maiden name.....

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

16. (a) Informant.....

(b) Address.....

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

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State..... (b) County.....  
 (c) City or town.....  
 (If outside city or town limits, write "RURAL")  
 (d) Street No.....  
 (If rural, give location)  
 (e) Citizen of foreign country?..... (Yes or No)  
 If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept Day 26 Year 1946 Hour 10 minute 36 M.

21. I hereby certify that I attended the deceased from.....  
 that I last saw him..... alive on.....  
 and that death occurred on the date and hour stated above.  
 Immediate cause of death.....

Due to.....

Due to.....

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

Major findings:  
 Of operations.....

Of autopsy.....

Duration  
 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)  
 (e) Means of injury.....

23. Signature..... (M. D. or other).....

Address..... Date signed.....

SUPPLEMENTARY

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

MOTHER FATHER

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MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

Registration District No. 839 Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Stoddard  
(b) City or town Richland Supp  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

Maggie Teacher Blunt

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex d

d

5. Color or race w

w

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

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Dec 2  
(Month) (Day) (Year)

8. AGE: Years 52 Months 9 Days 14 min. \_\_\_\_\_  
(If less than one day)

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER {

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_ (State or foreign country)

15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) Feb 6-42 (b) Mrs Nora Lyons  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Duration

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include 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) (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY