

DEC 23 1941

State File No. ....

Registration District No. 25-

Primary Registration District No. 50323.

Registrar's No. ....

1. PLACE OF DEATH:

(a) County. Andrew  
(b) City or town. South of town  
(c) Name of hospital or institution: Rural  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution. 50 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME SARAH JANE BLINCOE

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. John Blincoe 6. (c) Age of husband or wife if alive. 81 years  
7. Birth date of deceased. Feb 20 1866  
(Month) (Day) (Year)

8. AGE: Years 73 Months 9 Days 2 If less than one day hr. min.

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

10. Usual occupation. House wife

11. Industry or business

MOTHER FATHER { 12. Name Duke Kultz  
13. Birthplace Not known ?  
(City, town, or county) (State or foreign country)  
14. Maiden name Not known  
15. Birthplace Not known ?  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. S.B. Proffitt

(b) Address Martinsburg Mo

17. (a) Burial (b) Date thereof Nov 24 1941  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Unity Cemetery

18. (a) Signature of funeral director. J.W. Kuhn

(b) Address Wellsville Mo

19. (a) Nov 24 1941 (b) Mary C. Jacobi  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State. Mo (b) County. Andrew  
(c) City or town. Rural  
(d) Street No. Four South of Martinsburg Mo  
(If rural, give location)  
(e) Citizen of foreign country? (Yes or No)  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 22  
year 1941 hour 8 minute 15 M.

21. I hereby certify that I attended the deceased from Oct 22 1941 to Nov 22 1941  
that I last saw her alive on Nov 11 1941  
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchio-Pneumonia P. W. X

Due to Fracture Hip 1 M

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 004

(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 0

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

Address Wellsville Mo Date signed 11/25/41

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

4-41  
7-39  
X26390

RECEIVED

District Health Officer No. 10

District File Number 12-41-2225

Date Filed DEC 18 1941

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 Clifford C. Kuhn

Licensed Embalmer No. 3059

P. O. Address Wellsville, N.Y.

**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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. ....

Registration District No. ....

Primary Registration District No. ....

Registrar's No. ....

1. PLACE OF DEATH:

(a) County Judson  
(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 Laura J. Blincoe

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

4. Sex M. 5. Color or race W 6. (a) Single, widowed, married, divorced \_\_\_\_\_

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

7. Birth date of deceased Feb 20, 1866  
(Month) (Day) (Year)

8. AGE: Years 75 Months 9 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

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

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

11. Industry or 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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

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

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

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

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (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 \_\_\_\_\_ Day \_\_\_\_\_ Year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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

Immediate cause of death \_\_\_\_\_

Due to fracture hip  
fall

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify fracture hip)  
(b) Date of occurrence Oct 20, 1941  
(c) Where did injury occur? in own home MO. (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? in home

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury fall

23. Signature J. J. [unclear] (M. D. or other) \_\_\_\_\_  
Address Willisville Date signed 1-13-42

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

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-37686