

FILED JUN 8/1944

State File No.

Registration District No. 1

Primary Registration District No. 2428

Registrar's No. 74

1. PLACE OF DEATH:

(a) County Franklin
(b) City or town Sullivan, Rural
(c) Name of hospital or institution: Sullivan
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community 30 years (Specify whether years, months or days) (mother)

3. (a) PRINT FULL NAME Mary Theresa Blankenship

8. (b) If veteran, name war No 8. (c) Social Security No. None

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

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

7. Birth date of deceased May 30 1944
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day 3 hr. _____ min.

9. Birthplace Sullivan, R # 1 Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Child

11. Industry or business _____

12. Name Alvie E. Blankenship

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

14. Maiden name Elsie Strothkamp

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

16. (a) Informant Alvie E. Blankenship

(b) Address Sullivan, Missouri

17. (a) Burial (b) Date thereof May 31, 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Japan, Mo

18. (a) Signature of funeral director W. H. Hooper

(b) Address Sullivan, Missouri

19. (a) 6-2-44 (b) Don C. Celler
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Franklin
(c) City or town Sullivan, 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.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 30
year 1944 hour 8 minute _____ P. M.

21. I hereby certify that I attended the deceased from May 30
1944 to May 30, 1944
that I last saw h _____ alive on _____, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac weakness
mother just receiving
frank measles
wild high fever
Due to _____
Due to _____

Other conditions _____
(Include pregnancy within 5 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) _____
(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 W. H. Hooper (M. D. or other)
Address Sullivan, Mo Date signed 6/1/44

USE CONTINUING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No. 9

District File Number.....

Date Filed 6-7-44

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.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

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