

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

FILED JAN 26 1945

Primary Registration District No. 1002

Registrar's No. 79

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

JUN 16 1945

1. PLACE OF DEATH:

(a) County JACKSON

(b) City or town ICANSA CITY  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: ST. JOSEPH'S  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 9 DAYS  
(Specify whether years, months or days)

In this community 9 days  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State ARKANSAS (b) County 999

(c) City or town MAMMOTH SPRINGS  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country 2

3. (a) PRINT FULL NAME HENRY W. BLANCHARD

3. (b) If veteran, name war NO

3. (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 8  
year 1945 hour 12 minute 15 A. M.

21. I hereby certify that I attended the deceased from Jan. 1  
19 45 to Jan. 8 19 45

that I last saw h. 12 alive on Jan. 7 19 45  
and that death occurred on the date and hour stated above.

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife DELLA 6. (c) Age of husband or wife if alive 39 years

7. Birth date of deceased DECEMBER 23, 1868  
(Month) (Day) (Year)

Immediate cause of death Cerebral hemorrhage  
Duration \_\_\_\_\_

8. AGE: Years 76 Months 2 Days 16 If less than one day 15 hr. \_\_\_\_\_ min.

Due to Hypertension

Due to bronchial

Other conditions Hypostatic pneumonia  
(Include pregnancy within 3 months of death)

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

10. Usual occupation SWITCHMAN (RETIRED)

11. Industry or business Frisco & R.I.-R. R.

12. Name GREEN I. BLANCHARD

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

14. Maiden name MARY EATON

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

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

Major findings: Of operations 83a

Of autopsy \_\_\_\_\_

16. (a) Informant Mrs. Della Blanchard

(b) Address MAMMOTH SPRINGS, ARK.

17. (a) BURIAL (b) Date thereof 1-10-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MEMORIAL PARK, K.C.K.

18. (a) Signature of funeral director Geo. H. Long

(b) Address 703 N. 10th St. K. C. Mo.

19. (a) 1-8-45 (b) N. E. Brown  
(Date received local registrar) (Registrar's signature)

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 [Signature] (M. D. or other) \_\_\_\_\_

Address [Address] Date signed 1-8-45

Wm. M. Jackson  
Washington Field

JUN 16 1945

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 Chas H Rider  
Licensed Embalmer No. 3404  
P. O. Address 703 N. 10th KC, 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.