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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED DEC 29 1945

Primary Registration District No. 3000

Registrar's No. 63

1. PLACE OF DEATH: Adair

(a) County Adair

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

(c) Name of hospital or institution:
Grim-Smith Hospital & Clinic
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 days
(Specify whether _____)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Macon

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

(d) Street No. _____
(If rural, give location)

(e) Citizen of foreign country? no 1 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Henry J. Blew

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 22
year 1945 hour 12:30 P.M. minute _____ M.

4. Sex Male 5. Color or race White

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

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

7. Birth date of deceased: January 9 1883
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from November 20, 1945 to November 22, 1945;
that I last saw him alive on November 22, 1945;
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiorenal vasular disease
Duration 6 mos.

8. AGE: Years 62 Months 10 Days 13 If less than one day _____ hr. _____ min.

Due to _____

Due to _____

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

10. Usual occupation Retired Farmer

Other conditions Cerebral hemorrhage
(Include pregnancy within 3 months of death)

MOTHER FATHER

11. Industry or business _____

12. Name Frank Blew

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

14. Maiden name Susan J. Lingo

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

Major findings:
Of operations _____
Of autopsy _____

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

16. (a) Informant Mrs. Ross Blew

(b) Address R 4 Macon, Mo

17. (a) burial (b) Date thereof Nov 24-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Beverly Cemetery

18. (a) Signature of funeral director Albert Skinner

(b) Address Macon, Mo

19. (a) 11-28-45 (b) Kate Lambert
(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?
(Specify type of place) _____

While at work? _____ (e) Means of injury 0

23. Signature E. S. Smith (M. D. or other) _____
Address W. Co. Mo Date signed 12/23/45

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

RECEIVED

District Health Officer No. 10

District File Number 12-45-1879

Date Filed DEC 20 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 Albert S. Kinner

Licensed Embalmer No. 751

P. O. Address Macon 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.