

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED OCT 4 1952

 BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 590 Registrar's No. 2486

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Wellston</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN. <u>St. Louis</u> <u>2259</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Vincent's Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>25 Mark Train Hotel, 116 N. 8th St.</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Anna</u> b. (Middle) _____ c. (Last) <u>Bloomfield</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 23, 1952</u>		
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never Married</u>	8. DATE OF BIRTH <u>July 17, 1882</u>	9. AGE (In years last birthday) <u>69</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Real Estate Owner</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	11. BIRTHPLACE (State or foreign country) <u>New Madrid, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
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13a. FATHER'S NAME <u>James Bloomfield</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Hill</u>	14. NAME OF HUSBAND OR WIFE _____
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>Unknown</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mr. James Bloomfield (Nephew)</u>	ADDRESS <u>New Madrid, Missouri</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Hypertensive Cardiovascular Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ <u>443X</u>		
	DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>* See reverse side for Other Significant Conditions</u>			

19a. DATE OF OPERATION <u>None</u>	19b. MAJOR FINDINGS OF OPERATION <u>--</u>	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>None</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.) <u>9-23-52 6 a.m.</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 9-11, 1952, to 9-23, 1952, that I last saw the deceased alive on 9-23, 1952, and that death occurred at 5:30 a.m., from the causes and on the date stated above.

23a. SIGNATURES <u>S. B. BANETT M. D.</u> (Deceased or title)	23b. ADDRESS <u>457 N. Kingshighway</u>	23c. DATE SIGNED <u>9/23/52</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>9-24-52</u>	24c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>	24d. LOCATION (City, town, or county) (State) <u>NEW MADRID MO.</u>
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DATE REC'D BY LOCAL REG. <u>9-26-52</u>	REGISTRAR'S SIGNATURE <u>Herbert Donke M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>RICHARDS</u>	ADDRESS <u>NEW MADRID MO.</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

* Other Significant Conditions:	Interval between
Involuntional Psychotic Reaction	Onset & Death:
Hypertension, essential.	8 months
Arteriosclerosis, generalized	Unknown
Osteoarthritis, generalized.	Unknown
Kyphoscoliosis, dorsal spine.	Unknown
Ingrowing toe nail, great toe, left	Unknown
Fracture, acetabulum, left, occurred	1 day
during Electric Treatment.	

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

M. W. Ruster

Licensed Embalmer No. 4865

P. O. Address St Louis, 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, it should be so stated above.