

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **27447**

No. 300  
10-48

FILED AUG 10 1953

BIRTH NO. _____		REG. DIST. NO. <b>339</b>		PRIMARY REG. DIST. NO. <b>4501</b>		Registrar's No. <b>26</b>		
1. PLACE OF DEATH a. COUNTY <b>Stoddard</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Stoddard</b>				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Bloomfield</b>		c. LENGTH OF STAY (in this place) <b>Years</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Bloomfield</b>		1030		
d. FULL NAME OF HOSPITAL OR INSTITUTION				d. STREET ADDRESS (If rural, give location)				
3. NAME OF DECEASED (Type or Print) a. (First) <b>Lucy</b> b. (Middle) <b>Jane</b> c. (Last) <b>Bleakley</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Aug. 1, 1953</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>		8. DATE OF BIRTH <b>July 11, 1868</b> AGE (In years, months, days) <b>85</b> <input type="checkbox"/> UNDER 1 YEAR <input type="checkbox"/> 1 YEAR <input type="checkbox"/> 2 YEARS <input type="checkbox"/> 3 YEARS <input type="checkbox"/> 4 YEARS <input type="checkbox"/> 5 YEARS <input type="checkbox"/> 6 YEARS <input type="checkbox"/> 7 YEARS <input type="checkbox"/> 8 YEARS <input type="checkbox"/> 9 YEARS <input type="checkbox"/> 10 YEARS <input type="checkbox"/> 11 YEARS <input type="checkbox"/> 12 YEARS <input type="checkbox"/> 13 YEARS <input type="checkbox"/> 14 YEARS <input type="checkbox"/> 15 YEARS <input type="checkbox"/> 16 YEARS <input type="checkbox"/> 17 YEARS <input type="checkbox"/> 18 YEARS <input type="checkbox"/> 19 YEARS <input type="checkbox"/> 20 YEARS		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <b>Illinois Edgar County</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13a. FATHER'S NAME <b>Andrews Hughes</b>			13b. MOTHER'S MAIDEN NAME <b>Louisa Smith</b>		14. NAME OF HUSBAND OR WIFE <b>Virgil Bleakley</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>--</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Muriel Brown Bloomfield, Mo.</b> ADDRESS				
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Congestive Heart Failure 3da</b> ANTECEDENT CAUSES <b>Coronary Arteriosclerosis</b> DUE TO (b) <b>Coronary Arteriosclerosis</b> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS. Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <b>4201</b>					20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?				
22. I hereby certify that I attended the deceased from <b>Jan 20, 1943</b> to <b>Aug 1, 1953</b> that I last saw the deceased alive on <b>July 27, 1953</b> , and that death occurred at <b>7:00 A.M.</b> , from the causes and on the date stated above.								
23a. SIGNATURE <b>S. L. Davis M.D.</b> (Degree or title)				23b. ADDRESS <b>Doctor</b>		23c. DATE SIGNED <b>8/2/53</b>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>8-3-53</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Bloomfield Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>Bloomfield Stoddard Mo.</b>		
DATE REC'D BY LOCAL REG. <b>Aug. 5, 1953</b>		REGISTRAR'S SIGNATURE <b>Rose Webber</b> 355		25. FUNERAL DIRECTOR'S SIGNATURE <b>Chiles Und. Co.</b> ADDRESS <b>Bloomfield, Mo.</b>				

(Licensed Embalmer's Statement on Reverse Side)

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

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 Lester

Cooper # 3499

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed \_\_\_\_\_

Joan C. Cooper

Licensed Embalmer No. 4119

P. O. Address Bloomfield, 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.