

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

8834

State File No. ....

FILED APR 2 - 1956

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 5464 Registrar's No. 287

1. PLACE OF DEATH a. COUNTY <b>Greene</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Greene</b>	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <b>Near Willard, Missouri</b> ) c. LENGTH OF STAY (in this place) <b>60 yr</b>		c. CITY OR TOWN <b>Willard, Mo</b> d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> <b>90</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION: <b>The Family Home,</b>		e. STREET ADDRESS (If rural, give location) <b>R.F.D.2, Willard, Missouri</b>	

3. NAME OF DECEASED (Type or Print)	a. (First) <b>Sarah</b>	b. (Middle) <b>Cordia</b>	c. (Last) <b>Blankenship</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>March 26, 1956</b>
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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>Dec. 12, 1870</b>	9. AGE (In years last birthday) <b>85</b>	IF UNDER 1 YEAR Months <b>3</b> Days <b>14</b>	IF UNDER 12 HRS. Hours <b></b> Min. <b></b>
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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>Greenback, Tennessee</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>
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13a. FATHER'S NAME <b>Joe Humphreys</b>	13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	14. NAME OF HUSBAND OR WIFE <b>R.G. Blankenship, Dec/</b>
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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) <b>No</b>	16. SOCIAL SECURITY NO. <b>No</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Willard, Mo Mrs Jack Race, Mrs Ollie Fouraker.</b>
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cancer and of</b>		
	ANTECEDENT CAUSES DUE TO (b) <b>Shock</b> DUE TO (c) <b>Brown metastases</b>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>148X</b>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	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 Feb 1, 1956 to Mar 5, 1956, that I last saw the deceased alive on Mar 25, 1956, and that death occurred at 10.50 AM, from the causes and on the date stated above.

23a. SIGNATURE <b>W.D. DeKiel M.D.</b> (Degree or title)	23b. ADDRESS <b>Springfield Mo</b>	23c. DATE SIGNED <b>3/26/56</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>MARCH 28, 1956</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Murrays</b>	24d. LOCATION (City, town, or county) (State) <b>1 1/2 mi. S. W. Willard, Mo</b>
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DATE REC'D BY LOCAL REG. <b>3-28-56</b>	REGISTRAR'S SIGNATURE <b>Essie Williams</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Greenwade-Windle, Willard, Missouri</b>
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(Licensed Embalmer's Statement on Reverse Side)

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

No. 300  
10-48

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emb

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed..... *Bernard F. Wright*

Licensed Embalmer No. *429*

P. O. Address *Spring*

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

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.