

Health,  
& Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

18230  
STATE FILE NUMBER

FILED JUN 3 1957

Registration District No. 280 Primary Registration District No. 4421 Registrar's No. 33

5. 300  
1-57

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u> <u>Platte</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, give location) a. STATE <u>MISSOURI</u> b. COUNTY <u>JACKSON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>PARKVILLE</u>		c. CITY OR TOWN <u>PARKVILLE</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>613 West Street</u>		d. STREET ADDRESS (If outside, give location) <u>613 West St.</u>	

3. NAME OF DECEASED (Type or print) First <u>BLANCHE</u> Middle <u>TOREZ</u> Last <u>53 813</u>		4. DATE OF DEATH <u>May 19, 1957</u>	
---	--	--	--

5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 26, 1889</u>	9. AGE (In years last birthday) <u>68 yrs.</u> IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> IF UNDER 24 HRS. <u>0</u>
----------------------	-------------------------------	---	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Cincinnati, Ohio</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
--	-----------------------------------	---	--

13a. FATHER'S NAME <u>John Anderson</u>	13b. MOTHER'S MAIDEN NAME <u>Sophia Turner</u>	14. NAME OF HUSBAND OR WIFE <u>Frank Torez</u>
--	---	---

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>None</u>	17. INFORMANT Address <u>Frank Torez 613 West St.</u>
--	--	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) <u>Generalized arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 yr</u> <u>10 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (not related to the terminal disease condition given in PART I (a)) <u>331x</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
---	--

20c. TIME OF INJURY Hour <u>          </u> Month, Day, Year a.m. <u>          </u> p.m. <u>          </u>
---

20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY <u>          </u> STATE <u>          </u>
---	--	--

21. I attended the deceased from May 19, 1957, to May 19, 1957 and last saw her alive on May 19, 1957  
Death occurred at 12:30 9 m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>H. C. Therman M.D.</u>	(Degree or title)	22b. ADDRESS <u>11 East Parkville, Mo</u>	22c. DATE SIGNED <u>5-23-57</u>
---	-------------------	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>5-24-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parkville</u>	23d. LOCATION (City, town, or county) (State) <u>Parkville, Missouri</u>
---	-----------------------------	--	---

24. FUNERAL DIRECTOR <u>WATKINS BROS. FN. HM.</u>	ADDRESS <u>18th &amp; Benton</u>	25. DATE RECD. BY LOCAL REG. <u>5-23-1957</u>	26. REGISTRAR'S SIGNATURE <u>Alphie Rollins</u>
--	-------------------------------------	--	--

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

MAY 23 1958  
MAY 5 1957

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 .....  
Signature of Student Embalmer

Signed Bruce J. Watkins .....

Licensed Embalmer No. 4500 .....

P. O. Address 18th & Bee .....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.