

Health,
Welfare
Public
Service

FILED AUG 12 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

23575

STATE FILE NUMBER

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 849

100
-57

1. PLACE OF DEATH a. COUNTY BUCHANAN			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY SALINE		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. JOSEPH		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN SWEET SPRINGS		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION STATE HOSP. #2		Length of stay in 1b 9 P.M. 10 A.M. 22 DAYS		d. STREET ADDRESS (If outside, give location) 0978	
3. NAME OF DECEASED (Type or print) First Middle Last ANNA BELLE BLAIN			4. DATE OF DEATH Month Day Year JULY 19 1957		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 2, 1880		9. AGE (In years last birthday) 76
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER		10b. KIND OF BUSINESS OR INDUSTRY HOUSEWORK		11. BIRTHPLACE (City and state or country) ORRICK, MO	
10c. FATHER'S NAME Jesse B. BLAIN		13b. MOTHER'S MAIDEN NAME HANNA HUNTER		14. NAME OF HUSBAND OR WIFE NONE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address MARY FRANCES BLAIN (deceased)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic pneumonia					INTERVAL BETWEEN ONSET AND DEATH 16 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cardiac decompensation					Interval between onset and death Underlying
DUE TO (c) 4343F					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Fracture of neck of left femur					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input checked="" 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.) Fall on floor of Hospital ward			
20c. TIME OF INJURY Hour Month, Day, Year 11 a.m. 7-2-57					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Hospital ward.		20f. CITY, TOWN, OR LOCATION COUNTY STATE St. Joseph Buchanan Mo.	
21. I attended the deceased from: 7-2-57 to 7-19-57 and last saw her alive on 7-19-57 Death occurred at: 4:20 P. m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Mohammad Sam M.D.			22b. ADDRESS 1415 N. 24 St. St. Joseph		22c. DATE SIGNED 8-5-57
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE JULY 21, 1957		23c. NAME OF CEMETERY OR CREMATORY PISGAH Cemetery	
		23d. LOCATION (City, town, or county) SALINE COUNTY, Mo.		(State)	
24. FUNERAL DIRECTOR L. F. Parker		ADDRESS Sweet Springs, Mo		25. DATE RECD. BY LOCAL REG. July 26, 1957	
		26. REGISTRAR'S SIGNATURE Mrs. Robert Fulton			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 L. F. Parker

Licensed Embalmer No. 3840
P. O. Address Sweet Springs

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.