

FILED AUG 19 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28153

STATE FILE NUMBER

 Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 86

1. PLACE OF DEATH a. COUNTY <u>HOWELL</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>HOWELL</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>WEST PLAINS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>WEST PLAINS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>CHRISTA HOGAN</u>			Length of stay in 1b <u>10 DA.</u>		d. STREET ADDRESS (If outside, give location) <u>105 E. OLDEN</u>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>BASHIA LOUVENA BLAIR</u>				4. DATE OF DEATH Month Day Year <u>7-24-57</u>					
5. SEX <u>f</u>	6. COLOR OR RACE <u>W</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>1-9-1879</u>		9. AGE (In years last birthday) <u>78</u>		IF UNDER 1 YEAR Months Days <u>6 15</u>	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>X X</u>		11. BIRTHPLACE (City and state or country) <u>GEORGIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>		
13a. FATHER'S NAME <u>CHAS. WHITE</u>			13b. MOTHER'S MAIDEN NAME <u>MARY MITCHELL</u>			14. NAME OF HUSBAND OR WIFE <u>R. T. BLAIR</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>X X</u>			16. SOCIAL SECURITY NO. <u>X</u>		17. INFORMANT Address <u>ELMER BLAIR, SPRINGFIELD, MO</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>myocardial failure</u>								INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
Conditions, if any, which gave rise to above cause (a), stating the under- lying cause last. } DUE TO (b) <u>Bronchial pneumonia</u>								<u>7 days</u>	
DUE TO (c) <u>Carcinoma of lungs</u>								<u>9 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) <u>16 2 X</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 Month, Day, Year a.m. p.m.									
20d. INJURY OCCURRED WHILE AT WORK <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		STATE	
21. I attended the deceased from <u>1955</u> to <u>7/24/57</u> and last saw her alive on <u>7/24/57</u> Death occurred at <u>11:30 AM</u> on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>M. L. Fowler MD</u>				22b. ADDRESS <u>West Plains, Mo.</u>			22c. DATE SIGNED <u>8/12/57</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>		23b. DATE <u>7-25-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>OAK-LAWN</u>			23d. LOCATION (City, town, or county) <u>WEST PLAINS, MO</u>		(State)	
24. FUNERAL DIRECTOR ROBERTSON'S, WEST PLAINS, MISSOURI <u>Robertson's</u>				25. DATE RECD. BY LOCAL REG. <u>8-14-57</u>		26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>			

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *A. S. Roberts*

Licensed Embalmer No. *347*

P. O. Address *West Haven*

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.