

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

36294

STATE FILE NUMBER

FILED NOV 8 1957

Registration District No. 154

Primary Registration District No. 5575

Registrar's No. 95

S. 300 4  
v. 1-57

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Kansas</b> b. COUNTY <b>Johnson</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Rural Washington</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Prairie Village</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Gurtis Rest Home</b>		Length of stay in 1b	d. STREET ADDRESS <b>2227 W 77th St</b>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Blanche Bosworth</b>			4. DATE OF DEATH Month Day Year <b>10-30-57</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-27-81</b>	9. AGE (In years last birthday) <b>76</b>	IF UNDER 1 YEAR Months Days <b>0 0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Deputy Agent</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Internal Revenue</b>	11. BIRTHPLACE (City and state or country) <b>LACLEDE, MO.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>Martin Bosworth</b>		13b. MOTHER'S MAIDEN NAME <b>Laura Welsh</b>		14. NAME OF HUSBAND OR WIFE <b>-----</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>499 16 1249</b>	17. INFORMANT Address <b>Collis Bosworth, 2227 W 77th St</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Dehydration - Anemia</b>					INTERVAL BETWEEN ONSET AND DEATH <b>3 mos.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Metastatic Carcinoma</b>					<b>3 mos.</b>
DUE TO (c) <b>Carcinoma of Rectum</b>					<b>2 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>154X</b>					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 <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 <b>19 Sept. 1957</b> , to <b>30 Oct. '57</b> and last saw her alive on <b>30 Oct. '57</b> Death occurred at <b>7 P</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>William R. Roberts M.D.</b>			22b. ADDRESS <b>Grandview, Missouri</b>		22c. DATE SIGNED <b>10-31-57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>10-31-57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Laclede Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Laclede, Missouri</b>
24. FUNERAL DIRECTOR ADDRESS <b>Brothers Funeral Home, Laclede, Mo</b>			25. DATE RECD. BY LOCAL REG. <b>10-31-57</b>	26. REGISTRAR'S SIGNATURE <b>Darling Treadwell</b>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

JAN 13 1958

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 *Blake Glidden* .....

Licensed Embalmer No. *5019* .....  
P. O. Address *Laclede 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting. - - -

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