

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-012321

STATE FILE NUMBER

FILED APR 20 1959

Registration District No. 37 Primary Registration District No. 4049 Registrar's No. 17

1. PLACE OF DEATH a. COUNTY <i>Boone</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MO</i> b. COUNTY <i>MONROE</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>CENTRALIA</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>PARIS</i> 0690 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>HULEN REST HOME</i>		Length of stay in lb <i>4 MO.</i>	d. STREET ADDRESS (If outside, give location) <i>E. RUBEY ST.</i> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <i>MARY JANE BLANTON</i>			4. DATE OF DEATH Month Day Year <i>APRIL 8 1959</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>MARCH 19, 1872</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>AT HOME</i>	9. AGE (In years last birthday) IF UNDER 1 YEAR: Months Days Hours Min. <i>87 0 12</i> 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
11. BIRTHPLACE (City and state or country) <i>MONROE CO. MO.</i>		13a. FATHER'S NAME <i>JOHN R. POWELL</i>	
13b. MOTHER'S MAIDEN NAME <i>MARY JANE VAUGHN</i>		14. NAME OF HUSBAND OR WIFE <i>H. JACK BLANTON</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>NO.</i>		16. SOCIAL SECURITY NO. <i>DEPARTMENT OF YES HUSBAND</i>	17. INFORMANT Address <i>MRS EDGAR BLANTON SHELBYNA, MO.</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Artery Thrombosis involving respiratory center</i> DUE TO (b) <i>Cerebral arteriosclerosis</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Abscess of left Carotid gland</i>			INTERVAL BETWEEN ONSET AND DEATH <i>Hours</i> <i>years</i>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <i>332x</i>		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 _____ to <i>Apr 7, 1959</i> and last saw her alive on <i>Apr 7, 1959</i> Death occurred at <i>12:45 A.M.</i> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>Ralph Ward MD</i>		22b. ADDRESS <i>Centralia Mo.</i>	
22c. DATE SIGNED <i>4/10/59</i>		23. NAME OF CEMETERY OR CREMATORY <i>WALNUT GROVE</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>APR. 9, 1959</i>	
23c. LOCATION (City, town, or county) <i>PARIS, MO.</i>		(State)	
24. FUNERAL DIRECTOR <i>E.H. AGNEW</i>		ADDRESS <i>PARIS, MO.</i>	
25. DATE RECD. BY LOCAL REG. <i>April 14-1959</i>		26. REGISTRAR'S SIGNATURE <i>Maud McBride</i>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

JUL 13 1962

8
1

APR 23 1959

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 *E. H. Agnew*

Licensed Embalmer No. *4000*

P. O. Address *Paris, 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.