

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-016460

STATE FILE NUMBER

FILED MAY 13 1959 Registration District No. 340 Primary Registration District No. 3075 Registrar's No. 47

300
1-57

1. PLACE OF DEATH a. COUNTY Stoddard		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Stoddard	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Dexter		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Dexter 10310 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Residence		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 234 So. Walnut Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Mary Middle Etta Last Bloodworth			4. DATE OF DEATH Month April Day 26 Year 1959		
---	--	--	---	--	--

5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 10, 1875	9. AGE (In years from birthday) 83	IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
-------------------------	----------------------------------	---	--	--	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired House-wife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Essex, Missouri	12. CITIZEN OF WHAT COUNTRY? U. S. A.
--	--	-----------------------------------	--	---

13a. FATHER'S NAME William R. Taylor		13b. MOTHER'S MAIDEN NAME Martha Ann Susan Rhodes		14. NAME OF HUSBAND OR WIFE John P. Bloodworth (Dec'd)	
--	--	---	--	--	--

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 Mrs. Ruth Miller, Dexter, Missouri		
--	--	--	--	--	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) General debility of age				INTERVAL BETWEEN ONSET AND DEATH 3 years
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____				
DUE TO (c) _____				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)				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.) 794X		
---	--	--	---	--	--

20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____			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	STATE
--	--	------------------------------	--	--------	-------

21. I attended the deceased from **Aug 1952**, to **Apr 24 1959** and last saw her alive on **24 Apr 1959**
Death occurred at **11:45 P. M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE J L Waddle, M.D. (Degree or title)		22b. ADDRESS Dexter, Missouri		22c. DATE SIGNED 4-28-59
---	--	---	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-29-59	23c. NAME OF CEMETERY OR CREMATORY Dexter		23d. LOCATION (City, town, or county) (State) Dexter, Missouri
--	--	-----------------------------	---	--	--

24. FUNERAL DIRECTOR Strickland-Rainey ADDRESS Dexter, Mo.		25. DATE RECD. BY LOCAL REG. 5/6/59	26. REGISTRAR'S SIGNATURE Anita M. Garner <i>Rep Reg</i>		
---	--	---	---	--	--

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

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 *Lucille Rainey*

Licensed Embalmer No. *4983*

P. O. Address *Septis, 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.