

JRL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-009695

FILED VS FEB 23 1960

Registration District No. 373 Primary Registration District No. 4545 Registrar's No. 11

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>WEBSTER</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>WEBSTER</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>MARSHFIELD</u>	Length of stay in 1b <u>6 YRS</u>	c. CITY OR TOWN <u>MARSHFIELD MO</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		d. STREET ADDRESS (If outside, give location) <u>449 S. BUFFALO</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>BEN A BLUNT</u>			4. DATE OF DEATH Month Day Year <u>FEB 7 1960</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</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>12-14-1886</u>	9. AGE (last birthday) <u>73</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>RET FARMER &amp; GROCER</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>MISSOURI</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>

13a. FATHER'S NAME <u>JAMES A BLUNT</u>	13b. MOTHER'S MAIDEN NAME <u>MARY E. POTTER</u>	14. NAME OF HUSBAND OR WIFE <u>BESSIE JANE</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>499-40-9459</u>	17. INFORMANT Address <u>BESSIE BLUNT MARSHFIELD MO</u>

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Hemorrhage generalized</u>		<u>2-3 hours</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Leukemia, myelogenous, acute</u>	<u>2 1/2 to 3 months</u>
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Dec 59. Subtotal parathyroid due to duodenal ulcer</u>	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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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 a.m. p.m. Month, Day, Year	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 3/24/55 to 2/7/60 and last saw her alive on 2/6/60  
Death occurred at 11 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>J. M. Macdonnell MD</u>	(Degree or title)	22b. ADDRESS <u>marshfield, mo</u>	22c. DATE SIGNED <u>10 Feb 60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>2-9-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WELCH</u>	23d. LOCATION (City, town, or county) (State) <u>WEBSTER Co MO</u>
24. FUNERAL DIRECTOR <u>BARBER-EDWARDS MARSHFIELD</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>2-16-60</u>	26. REGISTRAR'S SIGNATURE <u>J. J. Foxman</u>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed R. W. Goble

Licensed Embalmer No. 384

P. O. Address Mt. Zion

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.