

# FEDERAL BUREAU OF INVESTIGATION FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

## -60-029348

FILED VS AUG 3 1960

STATE FILE NUMBER

Registration District No. 340 Primary Registration District No. 6152 Registrar's No. 62

INDEXED

1. PLACE OF DEATH a. COUNTY <b>STODDARD</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Stoddard</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Ledy</b>		Length of stay in 1b <b>10 Yrs.</b>		c. CITY OR TOWN <b>BERNIE,</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>2 Mi. S. Bernie, Mo.</b>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>Highway #25, So.</b>			Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>BLANFORD</b> Last <b>BLANFORD</b>				4. DATE OF DEATH <b>JULY 20, 1960</b> Month <b>JULY</b> Day <b>20</b> Year <b>1960</b>					
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>3-27-74</b>	9. AGE (last birthday) <b>86 Yrs.</b>		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMING</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>RETIRED</b>		11. BIRTHPLACE (City and state or country) <b>HOLLY CROSS, KY.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13a. FATHER'S NAME <b>JOHN EDWARD BLANFORD</b>			13b. MOTHER'S MAIDEN NAME <b>EMLEY EDDLION</b>			14. NAME OF HUSBAND OR WIFE <b>MINNIE NEIGHBORS</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>488-42-0330</b>		17. INFORMANT Address <b>XXXX</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>Cardiac Failure</b> <b>Cardiac Asthma</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>several years</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						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			
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 <b>January 1960</b> to <b>July 20, 1960</b> and last saw him alive on <b>July 20, 1960</b> Death occurred at <b>4:10 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <b>F. A. Mc Cormack, D.O.</b> (Degree or title)				22b. ADDRESS <b>Box 482, Bernie, Mo.</b>		22c. DATE SIGNED <b>7-22-60</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>July 25, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>CATHOLIC CEMETERY</b>		23d. LOCATION (City, town, or county) <b>WASHINGTON, IND.</b>					
24. FUNERAL DIRECTOR ADDRESS <b>DAY &amp; KNIGHT, INC. MALDEN, MO.</b>			25. DATE RECD. BY LOCAL REG. <b>7-29-60</b>	26. REGISTRAR'S SIGNATURE <b>Quita M. Danner</b>					

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MS  
REC 1 1961

**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 Raymond L. Duffin

Licensed Embalmer No. 4798

P. O. Address Berme, N.J.

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.