ISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

TMENT OF PUBLIC HEALTH AND WELFARE

-61-043904
STATE FILE NUMBER

AMENDED

Registration District No. 61 Primary Registration District No. 4107 Registrar's No. 37

FILED DEC 26 1961

DATE AMENDED | INSTEAD OF | SHOULD READ | ITEM NO. | DOCUMENT | BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY Cedar
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN El Dorado Springs — Length of stay in 1b 11 hours
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Cedar Co. Memorial Hospital — Inside Limits Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY Vernon
c. CITY OR TOWN Schell City — Inside Limits Yes ☐ No ☒
d. STREET ADDRESS R.F.D #1 (If outside, give location) — Reside on Farm Yes ☒ No ☐

3. NAME OF DECEASED (Type or print) First Clarence Middle Wilson Last Blakely

4. DATE OF DEATH Month December Day 19 Year 1961

5. SEX male
6. COLOR OR RACE white
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH Sept. 19, 1898
9. AGE (last birthday) 63 years — IF UNDER 1 YEAR Months Days — IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer
10b. KIND OF BUSINESS OR INDUSTRY Farm
11. BIRTHPLACE (City and state or country) Kiowa, Colorado
12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME Robert Lee Blakely
13b. MOTHER'S MAIDEN NAME Belle Harrington
14. NAME OF HUSBAND OR WIFE Effie Juanita Goodwin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) none

17. INFORMANT Effie Blakely Address Schell City, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary thrombosis (massive)
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

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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 12/15/61, to 12/17/61 and last saw her/him alive on 12/17/61
Death occurred at Cedar Cty Mem. Hosp. 10:40 PM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) [signature] M.D.
22b. ADDRESS 111½ W. Spring El Dorado Spgs Mo.
22c. DATE SIGNED 12/20/61

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE Dec. 21, 1961
23c. NAME OF CEMETERY OR CREMATORY Green Lawn Cemetery
23d. LOCATION (City, town, or county) Schell City (State) Mo.

24. FUNERAL DIRECTOR Lewis & Son ADDRESS Schell City, Mo.
25. DATE RECD. BY LOCAL REG. 12/20/61
26. REGISTRAR'S SIGNATURE Joe E. Dunham, Act Registrar

(Licensed Embalmer's Statement on Reverse Side)

DEC 27 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 me

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed Mrs. Frances Z. Lewis

Licensed Embalmer No. 4775

P. O. Address Schell City

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