

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-007785

FILED FEB 23 1962

Registration District No. 318

Primary Registration District No. 1003

1893

STATE FILE NUMBER

AMENDED

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS | | Length of stay in lb 30 YRS. | c. CITY OR TOWN ST. LOUIS |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION CHRISTIAN HOSP. | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 2315 HEBERT |
| 3. NAME OF DECEASED (Type or print) First NETTIE Middle BLAND Last | | 4. DATE OF DEATH Month 2 Day 13 Year 1962 | |

| | | | | | | |
|---|---------------------------|---|------------------------------------|---|--------------------------------|--|
| 5. SEX F | 6. COLOR OR RACE W | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 12-13-1894 | 9. AGE (last birthday) 67 | 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) HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY HOME | | 11. BIRTHPLACE (City and state or country) UNK. KY. | | 12. CITIZEN OF WHAT COUNTRY USA. |
| 13a. FATHER'S NAME DAVE VOYLES | | 13b. MOTHER'S MAIDEN NAME UNK. | | 14. NAME OF HUSBAND OR WIFE JACOB BLAND | | |

| | | | |
|--|--|-------------------------------------|-----------------------------------|
| 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 JACOB BLAND | Address 2315 HEBERT ST. |
|--|--|-------------------------------------|-----------------------------------|

| | | |
|--|--|----------------------------------|
| 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) Diffused purulent peritonitis involving small intestines | | 2 weeks |
| DUE TO (b) involving small intestines | | |
| DUE TO (c) nephrosclerosis 446x | | |

| | | |
|--|--|---|
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Subchronic abscess | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |
|--|--|---|

| | | |
|---|---|--|
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 **2-2-1962** to **2-13-1962** and last saw her alive on **2-13-1962**
 Death occurred at **8:10 P.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

| | | |
|---|---------------------------------------|---------------------------------|
| 22a. SIGNATURE Nicholas Klym (Degree or title) M.D. | 22b. ADDRESS 3701 No. 25th St. | 22c. DATE SIGNED 2-15-62 |
|---|---------------------------------------|---------------------------------|

| | | | |
|---|-------------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL | 23b. DATE 2-16-1962 | 23c. NAME OF CEMETERY OR CREMATORY LAKE CHARLES | 23d. LOCATION (City, town, or county) (State) ST. LOUIS COUNTY MO. |
|---|-------------------------------|---|--|

| | | | |
|---|------------------------------------|--|--|
| 24. FUNERAL DIRECTOR SUEDMEYER Y SONS | ADDRESS 3934 N. 20TH ST. | 25. DATE RECD. BY LOCAL REG. FEB 15 1962 | 26. REGISTRAR'S SIGNATURE Loan Smith, M.D. |
|---|------------------------------------|--|--|

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 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 me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Harvey Kahle

Licensed Embalmer No. 4596

P. O. Address St. Louis, 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.