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1-56

Diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

33050

STATE FILE NUMBER

FILED OCT 8 1957

Registration District No. 297 Primary Registration District No. 3057 Registrar's No. 112

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>Ray</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Ray</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Richmond</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Richmond</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 <u>503 North Main</u>		Length of stay in lb <u>75 years</u>	d. STREET ADDRESS (If outside, give location) <u>220 North Main</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Lelah</u> Middle <u>JANE</u> Last <u>BLANN</u>			4. DATE OF DEATH Month <u>October</u> Day <u>1</u> Year <u>1957</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 15 1873</u>	9. AGE (In years last birthday) <u>83</u> IF UNDER 1 YEAR Months <u>10</u> Days <u>17</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>+ Bookkeeping Managing Rooming House</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Rooming House</u>		11. BIRTHPLACE (City and state or country) <u>Wellbourne, Kansas</u>	
13. FATHER'S NAME <u>Lawrence Blann</u>			14. MOTHER'S MAIDEN NAME <u>Julia Graham</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mary Kathryn Blann, Catholic, Mo.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Thrombosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Generalized Arterio sclerosis</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) _____					INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>unknown</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13.2X			
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 _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____		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 <u>Oct. 2, 1954</u> to <u>Oct. 1, 1957</u> and last saw her <u>alive</u> on <u>Oct 1 - 57</u> Death occurred at <u>8:30 A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>H. W. Johnson, M.D.</u>			22b. ADDRESS <u>Richmond, Mo.</u>		22c. DATE SIGNED <u>10/4/57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Oct 3, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sumner Life</u>		23d. LOCATION (City, town, or county) (State) <u>Richmond, Mo.</u>
24. FUNERAL DIRECTOR <u>Quest-A-ile Funeral Home</u> <u>Richmond, Missouri</u>		25. DATE RECD. BY LOCAL REG. <u>10-5-1957</u>		26. REGISTRAR'S SIGNATURE <u>Malcolm Jackson</u>	

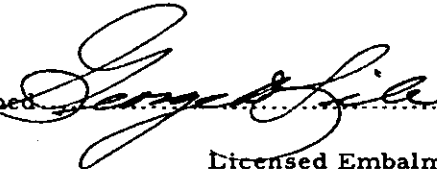
(Licensed Embalmer's Statement on Reverse Side)

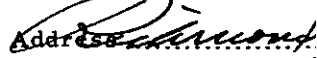
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STATEMENT BY LICENSED EMBALMER

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

Student.....  
Signature of Student Embalmer

Signed .....  
Licensed Embalmer No. 4064

P. O. Address 

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