DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 25 1946

Registration District No.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 36474

Primary Registration District No. 3017

Registrar's No. 116

1. PLACE OF DEATH:

(a) County ~~Boone~~ Cooper

(b) City or town Boonville
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Joseph's
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 days (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Moniteau

(c) City or town Fortuna
(If outside city or town limits, write "RURAL")

(d) Street No. —
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country none

3. (a) PRINT FULL NAME Virginia-Stella-Blankenship

3. (b) If veteran, name war none

3. (c) Social Security No.

4. Sex Female

5. Color or race White

6. (a) Single, ~~widowed~~, married, ~~divorced~~ Married

6. (b) Name of husband or ~~wife~~ Carl-M-Blankenship

6. (c) Age of husband or ~~wife~~ if alive 31 years

7. Birth date of deceased Feb (Month) 5 (Day) 1916 (Year)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Oct day 27 year 1946 hour 8 minute 15 A.M.

21. I hereby certify that I attended the deceased from Oct 25, 1946 to Oct 28, 1946; that I last saw h~~e~~r alive on Oct 27, 1946 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: undetermined pending results of autopsy	
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Major findings: Of operations none done

Of autopsy report not yet available

PHYSICIAN — Underline the cause to which death should be charged statistically.

	Years	Months	Days	If less than one day
8. AGE:	30	8	22	hr. ... min.

9. Birthplace Moniteau Co (City, town, or county) Mo (State or foreign country)

10. Usual occupation House wife

11. Industry or business At Home

MOTHER FATHER

12. Name Grover C. Scott

13. Birthplace Moniteau Co (City, town, or county) Mo (State or foreign country)

14. Maiden name Edith-Woods

15. Birthplace Moniteau Co (City, town, or county) Mo (State or foreign country)

16. (a) Informant Carl M. Blankenship

(b) Address Fortuna — Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-29-46 (Month) (Day) (Year)

(c) Place: burial or ~~cremation~~ Manuraie Cem-

18. (a) Signature of funeral director Keith McKaye

(b) Address Eldon Mo

19. (a) 11-9-46 (Date received local registrar) (b) [signature] (Registrar's signature)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature [signature] (M. D. or other)

Address 329 Main St. Boonville, Mo. Date signed 29 Oct 46

(Licensed Embalmer's Statement on Reverse Side)

3 81

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED
District Health Officer No. 8,

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~~ .....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Keith M Kaye

Licensed Embalmer No. 3998

P. O. Address Eldon Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Dec

Registration District No. 82 Primary Registration District No. 3017 Registrar's No. 116

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

35294

1. PLACE OF DEATH:

(a) County Cooper

(b) City or town (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days) In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town (If outside city or town limits, write "RURAL")

(d) Street No. (If rural, give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3. (a) PRINT FULL NAME Virginia S. Blankenship

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F | 5. Color or race W | 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive Yrs.

7. Birth date of deceased Feb. 5 (Month) (Day) (Year)

8. AGE: Years 30 | Months 8 | Days 22 | If less than one day hr. min.

9. Birthplace (City, town, or county) Mo (State or foreign country)

10. Usual occupation

11. Industry or Business

FATHER 12. Name

13. Birthplace (City, town, or county) (State or foreign country)

MOTHER 14. Maiden name

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Day year 1946 hour minute M.

21. I hereby certify that I attended the deceased from 25 Oct 46, 19..., to 27 Oct 46, 19...; that I last saw her alive on 27 Oct 46, 19...; and that death occurred on the date and hour stated above.

Immediate cause of death — Duration

a. cerebral hemorrhage — 7

Due to

Due to undetermined

Due to (autopsy revealed no evidence of trauma cause of hemorrhages unexplained)

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations none done
Of autopsy cerebral hemorrhage.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature Orie C. Von Ravenswaay MD (M. D. or other)

Address 329 Main St., Boonville Mo Date signed 29 Dec 46

SUPPLEMENTARY 47

36474