

## MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-005566

STATE FILE NUMBER

AMENDED

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 283

FILED MAR 12 1962

1. PLACE OF DEATH a. COUNTY <b>BUCHANAN</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>BUCHANAN</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. JOSEPH, MO.</b>		c. CITY OR TOWN <b>ST. JOSEPH, MO.</b>	
Length of stay in lb <b>35 YRS.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>2327 So. 11TH ST.</b>		d. STREET ADDRESS (If outside, give location) <b>2327 So. 11TH ST.</b>	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ETHEL</b> Middle <b>OLIVE</b> Last <b>BLAKLEY</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>7</b> Year <b>1962</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 10, 1888</b>
9. AGE (last birthday) <b>73</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWORK</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
11. BIRTHPLACE (City and state or country) <b>LIBERTY, MISSOURI</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>THOMAS ROBERTS</b>		13b. MOTHER'S MAIDEN NAME <b>MARTHA</b>	
14. NAME OF HUSBAND OR WIFE <b>-</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>NONE</b>	
17. INFORMANT <b>MRS. ROY BRUNS-WATHENA, KANSAS</b>		Address	
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>Cerebral Hemorrhage</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>36 hr.</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 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.) <b>62</b>	20f. CITY, TOWN, OR LOCATION <b>March 5th 1962</b>	
21. I attended the deceased from <b>March 5th 1962</b> to <b>March 7th 1962</b> and last saw her alive on <b>March 7th 1962</b> . Death occurred at <b>2:55 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>John S. Swails</b> (degree or title) <b>M.D.</b>		22c. DATE SIGNED <b>3-8-62</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE <b>MARCH 7, 1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>BELLEMONT CEMETERY</b>		23d. LOCATION (City, town, or county) <b>WATHENA, KANSAS</b>	
24. FUNERAL DIRECTOR <b>HARMAN FUNERAL HOME</b>		25. DATE RECD. BY LOCAL REG. <b>Mar. 9, 1962</b>	
26. REGISTRAR'S SIGNATURE <b>Mrs. Clark Goddell</b>			

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

J.G. SWAILS, M.D. MEDICAL CERTIFICATION

**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 Charles M. Harmon

Licensed Embalmer No. 4487

P. O. Address WATHENA, KANSAS

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.