

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **26756**

FILED AUG 19 1948

Registration District No. **79**

Primary Registration District No. **3028**

Registrar's No. **184**

1. PLACE OF DEATH:

(a) County **Jasper**
(b) City or town **Carthage**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
316 S. Fulton
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **Four weeks**
In this community **18 years** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **John F. Blinzler**

3. (b) If veteran,
name war

3. (c) Social Security No.

4. Sex **Male** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Lizzie Blinzler** 6. (c) Age of husband or wife if alive **years**
7. Birth date of deceased **April 30 1875**
(Month) (Day) (Year)

8. AGE: Years **73** Months **2** Days **20** If less than one day hr. min.

9. Birthplace **Blakesley Ohio**
(City, town, or county) (State or foreign country)

10. Usual occupation **Night Watchman**

11. Industry or business **Ozark Engineering Co.**

12. Name **Fredrick Blinzler**

13. Birthplace **Not Known**

14. Maiden name **Rose Phillips** (State or foreign country)

15. Birthplace **Not Known** (City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Lizzie Blinzler**

(b) Address **804 Rex Crossing**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **7-24-48** (Month) (Day) (Year)

(c) Place: burial or cremation **Ozark Memorial**

18. (a) Signature of funeral director **Thornhill-Dillon**

(b) Address **305 W. 4th.**

19. (a) **8-13-1948** (Date received local registrar) (b) **L. B. Clinton, M.D.** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jasper**
(c) City or town **Joplin**
(If outside city or town limits, write "RURAL")
(d) Street No. **804 Rex Crossing**
(If rural, give location)
(e) Citizen of foreign country? (Yes or No) **No**
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **21st.**
year **1948** hour **7:30 P.M.** minute **00** M.

21. I hereby certify that I attended the deceased from **6-19-48** to **7-3-48**
that I last saw him alive on **7-3-48**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral hemorrhage** Duration **6/19/48**

Due to
Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

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?

While at work? (Specify type of place) Means of injury

23. Signature **L. B. Clinton, M.D.** (M.D. or other)
Address **Joplin** Date signed **7/23/48**

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 Orvil A. Hornbree

Licensed Embalmer No. 3590

P. O. Address Joplin 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 this body is not embalmed, fact should be so stated above.