V. S. No. 2.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

# MISSOURI STATE BOARD OF HEALTH
## BUREAU OF VITAL STATISTICS
### CERTIFICATE OF DEATH

**PLACE OF DEATH**

County: Jasper County

Township or Village or City: Carthage (NO. ____ St.; ____ Ward)

Registration District No. 408 — File No. 35725

Primary Registration District No. 3020 — Registered No. 171

[If death occurred in a hospital or institution, give its NAME instead of street and number]

**FULL NAME** W L Blankenship

**PERSONAL AND STATISTICAL PARTICULARS**

SEX: Male

COLOR OR RACE: White

SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): married

DATE OF BIRTH: March 3 (Month) 1873 (Day) 1 (Year)

AGE: 41 yrs. 7 mos. 29 ds. — If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Hotel Keeper
(b) General nature of industry, business, or establishment in which employed (or employer): 23B 103B

BIRTHPLACE (City or town, State or foreign country): Jasper county mo.

NAME OF FATHER: AB Blankenship

BIRTHPLACE OF FATHER (City or town, State or foreign country): Tennessee

MAIDEN NAME OF MOTHER: Susan Harman

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Missouri

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Informant: Mrs W L Blankenship

(ADDRESS) 1982 Main St

Filed Nov 30, 1914. W E Steele, REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH: Nov 29 (Month) (Day), 1914 (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 24, 1913, to Nov 28, 1914, that I last saw him alive on Nov 28 1914, and that death occurred, on the date stated above, at 5 a.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory (Secondary) Haemorrhage (Duration) 1 yrs. 3 mos. ____ ds.

(Signed) David Wise M. D.

Nov 29, 1914 (Address) Carthage Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death?

Former or usual residence: Missouri

PLACE OF BURIAL OR REMOVAL: Solo Mo

DATE OF BURIAL: 12/1 1914

UNDERTAKER: T H Gimhart

ADDRESS: Carthage Mo

V. S. No. 2.

MARGIN RESERVED FOR BINDING

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N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

# MISSOURI STATE BOARD OF HEALT

## BUREAU OF VITAL STATISTICS

### CERTIFICATE OF DEATH

**PLACE OF DEATH**

County.....

Township ..... Registration District No. ..... File No. .....

*or*

Village..... Primary Registration District No. ..... Registered No. .....

*or*

City ..... (NO. ....., ..... St.: ..... Ward)

[If death occurred in hospital or institutio give its NAME inste of street and number]

**FULL NAME** .....

**PERSONAL AND STATISTICAL PARTICULARS**

| SEX | COLOR OR RACE | SINGLE<br>MARRIED<br>WIDOWED<br>OR DIVORCED<br>(*Write* the word) |
|---|---|---|
| | | |

DATE OF BIRTH

....., 1.....
(Month) (Day) (Year)

AGE

.....yrs. .....mos. .....ds.

If LESS than 1 day, .....hrs. or ....min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(ADDRESS) .....

Filed ....., 191....., .....
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH

....., 191..
(Month) (Day) (Yea

I HEREBY CERTIFY, that I attended deceased fr

....., 191....., to ....., 191..

that I last saw h.....alive on ....., 191..

and that death occurred, on the date stated above, at .....

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration).....yrs. .....mos. .....

Contributory .....
(SECONDARY)

.....(Duration).....yrs. .....mos. .....

(Signed) ..... M.

....., 191.... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, st (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, RECENT RESIDENTS)

At place of death.....yrs. .....mos. .....ds. In the State.....yrs. .....mos. .....

Where was disease contracted if not at place of death? .....

Former or usual residence .....

| PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL<br>....., 191. |
|---|---|
| UNDERTAKER | ADDRESS |