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

1 PLACE OF DEATH

County Greene

Township ..... Registration District No. 318 File No. 32931

or

Village ..... Primary Registration District No. 2001 Registered No. 775

or

City Springfield Mo (NO. Colored Hospital Ward)

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

2 FULL NAME Russell Blakey

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE Black

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Divorced

6 DATE OF BIRTH Sept. (Month) 28 (Day), 1885 (Year)

7 AGE 33 yrs. ..... mos. 28 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Cook —
(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE (City or town, State or foreign country) Mo —

PARENTS

10 NAME OF FATHER Sandy Blakey

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

12 MAIDEN NAME OF MOTHER Lizzie Steele

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lizzie Blakey

(Address) Greenfield Mo.

15 Filed OCT 26 1918, 191 Edwin F. James Registrar
Dollie B. Johnson
Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 10 (Month) 26 25 (Day), 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from 10-19, 1918, to 10-25, 1918, that I last saw him alive on 10-25, 1918, and that death occurred, on the date stated above, at 1a m.

The CAUSE OF DEATH* was as follows:

Influenza

11 10

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

CONTRIBUTORY (Secondary) .....

8 (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.

10-26, 1918 (Address) 32 O'Fallon Brook

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

18 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 .....

19 PLACE OF BURIAL OR REMOVAL S. Hazelwood

DATE OF BURIAL Oct. 27 1918

20 UNDERTAKER Parson Und. Co.

ADDRESS 410 South St.

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

1 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 a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH

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

7 AGE

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

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

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) .....

9 BIRTHPLACE
(City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

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

12 MAIDEN NAME OF MOTHER

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

....., 191.....
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191....., that I last saw h.....alive on ....., 191....., and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

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

CONTRIBUTORY .....
(Secondary)
..... (Duration).....yrs.....mos.....ds.

(Signed) .....M. D.

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

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

18 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 .....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191.....
20 UNDERTAKER	ADDRESS

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.

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

V. S. No. 2. A

RESERVED FOR BINDING