REGISTRAR'S RECORD

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: Scott

Township: Kilas

or

Village: Anvil

or

City: ~~Sikeston~~ (NO. ..... St. ..... Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number.]

Registration District No. Scott 1157 File No. 37423-L

Primary Registration District No. Cobb 7th Registered No. .....

2 FULL NAME Floyd Blattel

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

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

6 DATE OF BIRTH: June (Month) 9 (Day) 1910 (Year)

7 AGE: 8 yrs. 4 mos. 9 ds. If LESS than 1 day, ... hrs. or ..... min.?

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

9 BIRTHPLACE (City or town, State or foreign country): Scott Co., Mo

PARENTS

10 NAME OF FATHER: Charles Blattel

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Scott Co., Mo

12 MAIDEN NAME OF MOTHER: Emma [illegible]

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Scott Co., Mo

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charles Blattel
(Address) Anvil Mo

15 Filed 10/29, 1918 G. S. Leamon Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct (Month) 28 (Day) 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Oct 19th 191.. to Oct 28, 1918, that I last saw him alive on Oct 26, 1918, and that death occurred, on the date stated above, at Noon m.

The CAUSE OF DEATH* was as follows:
Pneumonia, bronchial
10 Th

(Duration) x yrs. x mos. 9 ds.

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

(Signed) L. L. Mayfield M. D.
Oct 28, 1918 (Address) Illmo, Mo

*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: Kelso Mo — DATE OF BURIAL: 10/29, 1918

20 UNDERTAKER: M. Nelle — ADDRESS: Kelso Mo

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

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

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