

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

38820

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

1 PLACE OF DEATH

County Shelby

Township

or

Village

or

City

Registration District No. 831

File No.

Primary Registration District No. 4504Registered No. 30

(NO.

St.

Ward)

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

2 FULL NAME Artimesa Wallace Blackburn

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

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

6 DATE OF BIRTH

April 28, 1847
(Month) (Day) (Year)

7 AGE

73 yrs. 7 mos. 20 ds.If LESS than
1 day.....hrs.
or.....min.?

8 OCCUPATION

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

Housewife

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

9 BIRTHPLACE

(City or town; State or foreign country)

Born les. Ky.

PARENTS

10 NAME OF FATHER

Daniel Rudger

11 BIRTHPLACE OF FATHER

(City or town, State or foreign country)

Ky

12 MAIDEN NAME OF MOTHER

Harriet McHatten

13 BIRTHPLACE OF MOTHER

(City or town, State or foreign country)

Ky.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

S. G. Blackburn

(Address)

Shelbyville, Mo.

15

Filed

Dec 17, 1920 W. A. Carson

Registered

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Nov 17, 1920
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from

April 1, 1920 to Dec 16, 1920that I last saw him alive on Dec. 16, 1920and that death occurred, on the date stated above, at 5:00 a.m.

The CAUSE OF DEATH* was as follows:

Chronic NephritisSanguine Right Lung114 lbs. (Duration) 0 yrs. 0 mos. 10 ds.CONTRIBUTORY Chronic Nephritis
(Secondary)(Duration) 1 yrs. 0 mos. 0 ds.(Signed) W. A. Carson M. D.Dec. 17, 1920 (Address) Shelbyville, 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

DATE OF BURIAL

Prairie View Cem. Dec. 18, 1920

20 UNDERTAKER

ADDRESS

W. A. Carson Shelbyville, Mo.

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.

LOCAL REGISTRAR'S RECORD--DO NOT TEAR LEAF OUT

1 PLACE OF DEATH

County

Township

or

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or

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(NO.

Primary Registration District No.

St.

Ward)

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File No.

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

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

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)

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

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:

CONTRIBUTORY
(Secondary)
(Duration) yrs. mos. ds.
(Signed) (Duration) yrs. mos. ds.
(Address) 191 (Address) M. D.

*State the Disease Causing Death, or in death 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.