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

Do not use this space.

JUL 20 1927

D. Wilbur Smith 318

18010

1. PLACE OF DEATH

County Greene

Registration District No.

Township Springfield

Primary Registration District No. 7004

File No.

Registered No. 354

City Springfield (No. Springfield Hospital St. Ward)

2. FULL NAME Elza Blackwell

(a) Residence. No. Wheatland Mo. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS		
3. SEX: m	4. COLOR OR RACE: w	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): married

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Bella Brashears

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 25 - 1892

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ......min.
	34	10	13	

8. OCCUPATION OF DECEASED

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

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY) Mo.

PARENTS

10. NAME OF FATHER S. S. Blackwell

11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Mo.

12. MAIDEN NAME OF MOTHER Amelia Frazier

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Mo.

14. INFORMANT Mrs. E. Blackwell
(Address) Wheatland Mo.

15. FILED 6/9 1927 O C Horst Reg.
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6 - 8 - 1927

17. I HEREBY CERTIFY, That I attended deceased from 6 - 3 - 1927, to 6 - 8 - 1927

that I last saw him alive on 6 - 8 - 1927 and that death occurred, on the date stated above, at 10:30 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

121B General Peritonitis
122B
129

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (SECONDARY) Intestinal obstruction

(duration) yrs. mos. 2 ds.

Before operation

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? Wheatland

DID AN OPERATION PRECEDE DEATH? yes DATE OF June 6 - 27

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) Wilbur Smith M. D

6/9 - 1927 (Address) Springfield Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Hastings Mo. ship

DATE OF BURIAL 6-10 1927

20. UNDERTAKER Hermitage Mo. W. T. Harris

ADDRESS Warsaw

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

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.
County Greene Registration District No. 318 File No.
Township Primary Registration District No. 2001 Registered No. 354
City Springfield (No.) St. Ward)

2. FULL NAME Clark Blackwell

(a) Residence. No. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE | YEARS | MONTHS | DAYS | If LESS than 1 day, ...hrs. or ....min.

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

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY)

14. INFORMANT
(Address)

15. Filed 6/9/27 O C Forstner
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 8 1927

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19....
that I last saw h... alive on ....., 19....., and that death occurred, on the date stated above, at ....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

General Peritonitis

Appendicular trouble, inflammation

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Intestinal Obstruction

before operation (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) ....., M. D
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

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

SUPPLEMENTARY

1190

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

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

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS ...

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