

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

Do not use this space.

5013
619

1. PLACE OF DEATH

County Jackson
Township Frank
City Kennett (No. 2614)

Registration District No. 399
Primary Registration District No. 1002

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 2614 Bell, St. 14 Ward. _____
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 7 yrs. 10 mos. 14 ds. How long in U.S., if of foreign birth? 7 yrs. 10 mos. 14 ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 8 - 1863

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>64</u>	<u>2</u>	<u>6</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Saliceman
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

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

10. NAME OF FATHER Blackman

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

12. MAIDEN NAME OF MOTHER Miss Harris

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

14. INFORMANT Arner L Blackwell
(Address) 111 West 18th St

15. FILED 7/15, 1928 M M Lowme
Asor REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb-14 1928

17. I HEREBY CERTIFY, That I attended deceased from Feb 11th, 1928, to Feb 14th, 1928, that I last saw him alive on Feb 14th, 1928, and that death occurred, on the date stated above, at Asor.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Myocarditis Chronic
9013
Gentle Defec. Loewme
from Tenn.
(duration) 6 yrs. 6 mos. 6 ds.
(SECONDARY) (duration) 6 yrs. 6 mos. 6 ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH: _____

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS Symptoms and Smears
(Signed) Clayton K Cooper, M. D.
7/15, 1928 (Address) 626 Lehigh Valley

*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 Memorial Park DATE OF BURIAL Feb-16 1928

20. UNDERTAKER Mrs. C. L. Foster ADDRESS K.C. Mo.

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.

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01.11.1994
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