3 23 192

72
0
0

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

Do not use this space.
2685

1. PLACE OF DEATH
County: New Madrid
Township: Como
City: ..... (No. ....., ... St. ..... Ward)

Registration District No. 225
Primary Registration District No. 5-8-3-7

File No. .....
Registered No. .....

2. FULL NAME: Charles Sylvester Blackman

(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)
Male	White	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Jan. 3, 1869

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	60		10	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Physician
(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): Illinois

PARENTS
10. NAME OF FATHER: William S. Blackman
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY): Illinois
12. MAIDEN NAME OF MOTHER: Sarah Hutchinson
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY): Illinois

14. INFORMANT: Claude Blackman,
(Address): Parma, Mo.

15. FILED: Jan 16 19 29 Mrs C. S. Blackman, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Jan. 13, 1929

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 8:25 A.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

(Influenza-Meningitis)

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....

..... (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) W. W. Dawson, M. D.
, 19 (Address) Hutch Ga.

*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: Dexter Cemetery
DATE OF BURIAL: Jan. 15, 29

20. UNDERTAKER: L. M. Hill
ADDRESS: Lilbourn,

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.

213
2
2
2
2