

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

Do not use this space.

21987

929

1. PLACE OF DEATH

County Linn
Township _____
City Marshall (No. Memorial Hospital)

Registration District No. 502
Primary Registration District No. 4315

File No. _____
Registered No. 31
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. Marshallfield wis St. _____ Ward. Marshallfield Wis.
(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 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 _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 8 1860

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
68 11 24

8. OCCUPATION OF DECEASED

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

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

10. NAME OF FATHER Erastus Blodgett

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

12. MAIDEN NAME OF MOTHER " "

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

14. INFORMANT July E Blodgett
(Address) Marshallfield wis

15. FILED 6/3 1929 Old Oytman REGISTRAR
P. Z.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 1 1929

17. I HEREBY CERTIFY, That I attended deceased from _____
June 1 1929, to June 1 1929
that I last saw him alive on June 1 1929, and that death occurred, on the date stated above, at 12:00 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Myocardial infarction

94A (duration) _____ yrs. _____ mos. 1/2 ds.

CONTRIBUTORY (SECONDARY) 89 (duration) _____ yrs. _____ mos. _____ ds.

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

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS _____
(Signed) Chas. P. ... M. D.
6/2 1929 (Address) Marshallfield Wis

*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 Marshallfield Wis DATE OF BURIAL June 2 1929

20. UNDERTAKER Jan W. Taughlin ADDRESS Marshallfield

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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