

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

Do not use this space.

25769

1. PLACE OF DEATH

County St. Louis
Township Carondelet
City Koch (No. 1123)

Registration District No. 1123
Primary Registration District No. 6248

File No. _____
Registered No. 283
St. _____ Ward _____

2. FULL NAME

Blackard, Thomas

(a) Residence No. 2106 Waverly Place Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred X yrs. 1 mos. 16 da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 20 1886

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
43 6 4

8. OCCUPATION OF DECEASED

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

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

PARENTS

10. NAME OF FATHER Riley Blackard

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

12. MAIDEN NAME OF MOTHER Mary Nelson

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

14. INFORMANT R. Koch Hospital Records
(Address) Koch Ho.

15. FILED July 25 1929 L. C. Obrock, M.D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 24 1929

17. I HEREBY CERTIFY That I attended deceased from June 8 1929 to July 24 1929 that I last saw him alive on July 24 1929, and that death occurred, on the date stated above, at 8:40 PM.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pulmonary Tuberculosis

31
About 31 (duration) X yrs. 6 mos. da.
CONTRIBUTORY Unknown
(SECONDARY)

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

DID AN OPERATION PRECEDE DEATH? No DATE OF _____
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? X Ray & Sputum
(Signed) Geo. S. Rosen, M. D.

7/25/29 (Address) Koch Hospital

*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

New St. Marcus Cem. 7-26 1929

20. UNDERTAKER ADDRESS

McLaughlin 1631 mo ave

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.

888 1929
26

