

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

11726

21. PLACE OF DEATH  
 County Buchanan Registration District No. 85  
 Township Dr Joseph Mo Primary Registration District No. 1001  
 City State Hospital No 2 Registered No. 437 St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME Robert Blackwell  
 (a) Residence. No. Dr Joseph 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 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) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Not known

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>58</u>			

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

9. BIRTHPLACE (CITY OR TOWN) Not known  
 (STATE OR COUNTRY)

10. NAME OF FATHER Not known

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Not known  
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Not known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Not known  
 (STATE OR COUNTRY)

14. INFORMANT State Hospital Records  
 (Address) Dr Joseph Mo

15. FILED 1930  
John G. Giff REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 9 1930

17. HEREBY CERTIFY, That I attended deceased from Feb 7 1930 to Apr 9 1930  
 that I last saw him alive on Apr 9 1930 and that death occurred, on the date stated above, at \_\_\_\_\_ m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Chronic Endocarditis

92A

CONTRIBUTORY (SECONDARY) 90A  
 (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) B E Miles M. D.

April 15 1930 (Address) Dr Joseph Mo  
 \*State the DISEASE CAUSING DEATH, or in death from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Lawson Mo DATE OF BURIAL Apr 10 30

20. UNDERTAKER J M Ward ADDRESS Lawson Mo

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—THIS IS A PERMANENT RECORD

MAY 22 1930

