

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

Do not use this space.

13515

MAY 27 1930

1. PLACE OF DEATH

County Des Moines Registration District No. 651
Township Little Prairie Primary Registration District No. 2862
City _____ (No) _____ St. _____ Ward _____

File No. _____
Registered No. 46
St. _____ Ward _____

2. FULL NAME

Mary Blacker
(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 Female 4. COLOR OR RACE Black 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widow
(write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) D.K.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
About 90,

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work 2nd Clerk
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

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

10. NAME OF FATHER Nathan Jackson

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

12. MAIDEN NAME OF MOTHER D.K.

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

14. INFORMANT Martha Anderson
(Address) Operry 720

15. FILE Apr 16 30 Ada Martin
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4/24 1930

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, and that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____, 8-19 P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Influenza
113 Clinical History
1620 (duration) yrs. mos. ds.

CONTRIBUTORY Senility
(SECONDARY) (duration) yrs. mos. 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? Clinical (exam)

(Signed) James P. Vickrey M. D.

4/26 10 30 (Address) Beggold 720

*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 New Madrid, Mo. DATE OF BURIAL 4/27 1930

20. UNDERTAKER J. H. Smith ADDRESS Operry 720

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.

