

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

Do not use this space.

20069

**1. PLACE OF DEATH**

County Miss.  
Township Sumner  
City Charleston (No. ....)

Registration District No. 566  
Primary Registration District No. 3030

File No. ....  
Registered No. 48  
St. .... Ward)

**2. FULL NAME**

(a) Residence No. .... St., .... Ward.  
(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX M- 4. COLOR OR RACE Wh. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 24 - 1851

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, .... hrs. or .... min.  
79 12

**8. OCCUPATION OF DECEASED**

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

9. BIRTHPLACE (CITY OR TOWN) Trigg Co. Ky  
(STATE OR COUNTRY)

10. NAME OF FATHER Dont Know  
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Dont Know  
(STATE OR COUNTRY)  
12. MAIDEN NAME OF MOTHER Dont Know  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Dont Know  
(STATE OR COUNTRY)

14. INFORMANT Mrs. W. M. Cagle  
(Address) RFD #2 - Charleston Mo

15. FILED June 11 1930 P. J. Vernon  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6/5 - 1930

17. I HEREBY CERTIFY, That I attended deceased from 8:30 - P.M.  
Apr 1st, 1930, to 6/5, 1930  
that I last saw him alive on 6/4, 1930, and that death occurred, on the date stated above, at 8:30 P.M.

18. THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
injured received in  
Feb. 1930  
(automobile accident)

CONTRIBUTORY (SECONDARY) severely 210M  
(duration) yrs. mos. ds.  
8 11-20  
(duration) yrs. mos. ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH.....

1 DID AN OPERATION PRECEDE DEATH? yes DATE OF Feb 1930

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Clinical sympt  
(Signed) E. Ches. Polwing M. D.  
, 19 (Address) Charleston, Mo.

\*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 D. O. F. Cemetery DATE OF BURIAL 6/7 1930

20. UNDERTAKER The Fair Und. Co. ADDRESS Charleston Mo  
400 Fair

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.

82625

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

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Miss

Registration District No. 366

File No. \_\_\_\_\_

Township \_\_\_\_\_

Primary Registration District No. 3030

Registered No. 48

City Charleston (No. \_\_\_\_\_)

St. \_\_\_\_\_

Ward \_\_\_\_\_

**2. FULL NAME**

James Madison Blanks

(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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED M (write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) \_\_\_\_\_

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work \_\_\_\_\_  
(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)

10. NAME OF FATHER \_\_\_\_\_

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

12. MAIDEN NAME OF MOTHER \_\_\_\_\_

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

**14.**

INFORMANT \_\_\_\_\_  
(Address)

**15.**

FILED Aug 11<sup>th</sup> 1930 F S Vernon  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 5 1930

17. I HEREBY CERTIFY That I attended deceased from \_\_\_\_\_, 19\_\_\_\_

that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

**THE CAUSE OF DEATH WAS AS FOLLOWS:**

Injuries received in Feb. 4, 1930 - auto accident - Mississippi County, Mo.  
(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) \_\_\_\_\_, M. D.  
, 19\_\_\_\_ (Address)

\*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 \_\_\_\_\_

20. UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

**SUPPLEMENTARY**

**1880**

N. E. ... any item of information 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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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