

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

OCT 31 1930

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

1. PLACE OF DEATH  
County: Oregon Registration District No. 636 File No. 30667  
Township: Goble Primary Registration District No. 5840 Registered No. \_\_\_\_\_  
City: \_\_\_\_\_ (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME: John Bartley Blankenship  
(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 53 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): Widower  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Widow  
6. DATE OF BIRTH (MONTH, DAY AND YEAR): Dec. 13 1859  
7. AGE: YEARS 83 MONTHS 9 DAYS 5 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work: Farming  
(b) General nature of industry, business, or establishment in which employed (or employer): \_\_\_\_\_  
(c) Name of employer: \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) MO  
(STATE OR COUNTRY) Lower Pa  
10. NAME OF FATHER: John Blankenship  
11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_  
(STATE OR COUNTRY) unknown  
12. MAIDEN NAME OF MOTHER: Sally Barton  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_  
(STATE OR COUNTRY) unknown

14. INFORMANT: Henry Blankenship  
(Address) \_\_\_\_\_  
15. FILED: 10/10, 1930 Smith Bailey  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

15. DATE OF DEATH (MONTH, DAY AND YEAR): Sept 14 1930  
17. I HEREBY CERTIFY That I attended deceased from 9/9, 1930, to 9/9, 1930 that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at 5 \_\_\_\_\_ p. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
thrombosis  
CONTRIBUTORY (SECONDARY): measles (duration) 4 yrs. mos. ds.  
(duration) \_\_\_\_\_ yrs. mos. ds. 10 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: General Observation  
(signed) A. B. Barrett, M. D.  
, 19\_\_\_\_ (Address) Alton 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. (See reverse side for additional space.)  
19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Bailey DATE OF BURIAL: 9/20 1930  
20. UNDERTAKER: W R Heller ADDRESS: Alton 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.

# Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more specific specification, as *Day laborer, Farm laborer, Miner—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework* or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report

"Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, OR HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

**NOTE.**—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, oryalsplac, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

Did this 83 year  
old man have

measles?

Yes He had the measles

several years ago. Which is claimed  
to bring out Proxeter's know his  
over 50 years he always claimed it

of

of p

for

ice

assign

30667  
(1930)

cated by check marks, recording

Name:

*John Bartley Blankenship*

Who died at:

*Oregon Co.*

on

*Sept. 18, 1930,*

Residence: No. \_\_\_\_\_

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

(If nonresident, city or town)

Length of residence in city or

town where death occurred: Years \_\_\_\_\_

Months \_\_\_\_\_

Days \_\_\_\_\_

\_\_\_\_\_

Sex: \_\_\_\_\_

Color or race: \_\_\_\_\_

Single, married, widowed or divorced: \_\_\_\_\_

Date of birth: \_\_\_\_\_

\_\_\_\_\_

Age: Years \_\_\_\_\_

Months \_\_\_\_\_

Days \_\_\_\_\_

Occupation: (a) Trade \_\_\_\_\_

\_\_\_\_\_

(b) Industry \_\_\_\_\_

Birthplace (State or country) \_\_\_\_\_

\_\_\_\_\_

Birthplace of father (State or country) \_\_\_\_\_

\_\_\_\_\_

Birthplace of mother (State or country) \_\_\_\_\_

CAUSE OF DEATH:

*Bronchitis*

*caused by measles hitting on or in Bronchial tubes  
of long duration*

Contributory: \_\_\_\_\_

*Measles*

Where was disease contracted? \_\_\_\_\_

Did operation precede death? \_\_\_\_\_

Date of \_\_\_\_\_

S-30667