

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.

APR 27 1931

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

Do not use this space.

12856

1. PLACE OF DEATH

County Shannon
Township Newton
City Newton (No.)

Registration District No. 1125
Primary Registration District No. 6082

File No.
Registered No.
St. Ward

2. FULL NAME

(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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE H 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF H. J. Blake

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr-9-1882
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
48 10 22

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Genl
(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) Mo

10. NAME OF FATHER J. J. Blunkhall

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

12. MAIDEN NAME OF MOTHER Nancy Buntley

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

14. INFORMANT Robert Blake
(Address) Round Springs Mo

15. FILED 3-1-1931

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar-1-1931

17. I HEREBY CERTIFY, That I attended deceased from Mar-1-1931 to Mar-1-1931, (that I last saw him alive on Mar-20-1931, and that death occurred, on the date stated above, at 3-30 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Laryngeal Tuberculosis

(duration) yrs. mos. da. 2 3

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. da.

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) Frank J. Taylor, M. D.
3-1-1931 (Address) Round Springs 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 DATE OF BURIAL

Madison County 3-2-1931

20. UNDERTAKER ADDRESS None

It is very important
that should state

by class
A A

Photo
of or

8.5

**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 Shannon
Township Newton
City Myrtle (No. Blake)

Registration District No. 1125-
Primary Registration District No. 6082

File No.
Registered No.
St. Ward)

2. FULL NAME

Myrtle Blake

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF W. F. Blake

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr 9-1882

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
48 10 22 — — —

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife
(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)

10. NAME OF FATHER T. J. Blunkell

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

12. MAIDEN NAME OF MOTHER Lucy Benth

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

14. INFORMANT Robert Blake
(Address) Round Springs, Mo

15. FILED 529, 1931 Camilla Dugh
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar-1 19 31

17. I HEREBY CERTIFY, That I attended deceased from Nov 1 1931 to Mar 1 1931
that I last saw him or her alive on Feb 29 1931 and that death occurred, on the date stated above, at 3-30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Laryngeal Tuberculosis

CONTRIBUTORY (SECONDARY)

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) Frank Hyde, M. D.
3-1 19 31 (Address) Eminence 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 Medley Cemetery DATE OF BURIAL 3-2 19 31
ADDRESS

20. UNDERTAKER None

N. B.—Every item of information should be classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR THIS SUPPLEMENTARY.

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