

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.

SEP 22 1931

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

Do not use this space.

27673

1. PLACE OF DEATH

County Camden  
Township Osage  
City Osage (No. 5167)

Registration District No. 117  
Primary Registration District No. 5167

File No. 16  
Registered No. 16 St. 16 Ward 16

2. FULL NAME

(a) Residence, No. Roxanna Blankenship St. 16 Ward 16

(Usual place of abode) 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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>F</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>wife</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Aug 19 1931</u>		
7. AGE <u>45</u>	YEARS <u>6</u>	MONTHS <u>24</u>
DAYS <u>24</u>		If LESS than 1 day, hrs. or min.

OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.	11. Total time (years) spent in this occupation
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.	
	10. Date deceased last worked at this occupation (month and year)	

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)  
Whitely La

13. NAME  
J. C. Grant

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)  
Tennepesee

15. MAIDEN NAME  
Murphy

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)  
Mo

17. INFORMANT (ADDRESS)  
M. Blankenship

18. BURIAL, CREMATION, OR REMOVAL  
PLACE Roach DATE Aug 20 1931

19. UNDERTAKER (ADDRESS)  
Abbie Bankson

20. FILED Sept 10 1931 Lizzie Keller Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 19 1931  
22. I HEREBY CERTIFY, That I attended deceased from Aug 2 1931 to Aug 19 1931  
I last saw him alive on Aug 19 1931. Death is said to have occurred on the date stated above, at 9:10 a.m.  
The principal cause of death and related causes of importance were as follows:

Typhoid fever  
Other contributory causes of importance: ✓  
Date of onset 14 days

Name of operation ✓ Date of ✓  
What test confirmed diagnosis? ✓ Was there an autopsy? ✓

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? ✓ Date of injury 19  
Where did injury occur? ✓ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury ✓  
Nature of injury ✓

24. Was disease or injury in any way related to occupation of deceased? no  
If so, specify no  
(Signed) A. J. Clarke M. D.  
(Address) Montreal Mo



**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 Cass  
Township Osage  
City Roxanna (No. ....) St. .... Ward)

Registration District No. 117  
Primary Registration District No. 5167

File No. ....  
Registered No. 16

**2. FULL NAME**

Roxanna 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 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 Dec-25-

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 25 1886

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
45 6 24

**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 Sep 11 1931

Lizzie L. Keller  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 19 1931

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

THE CAUSE OF DEATH WAS AS FOLLOWS:

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

19

SUPPLEMENTARY

Item of Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state EXACTLY the 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

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