

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

Do not use this space.

MAR 24 1934

1. PLACE OF DEATH

County.....
Township.....
City.....

Registration District No. **791**
Primary Registration District No. **1003**

File No. **7204**
Registered No. **2087**
St. Ward)

2. FULL NAME

(a) Residence, No.
(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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <i>Girl</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <i>Single</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <i>Single</i>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <i>Feb 29, 1928</i>		
7. AGE	YEARS <i>5</i>	MONTHS <i>11</i>
	DAYS <i>29</i>	IF LESS than 1 day, ... hrs. or min.

OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <i>None</i>
	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)
	11. Total time (years) spent in this occupation

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

13. NAME
Elmer Blackwell

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

15. MAIDEN NAME
Hazel Grider

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

17. INFORMANT (ADDRESS)
Elmer Blackwell
Island Mo.

18. BURIAL, CREMATION, OR REMOVAL
PLACE *Island Mo.* DATE *Feb 28, 1934*

19. UNDERTAKER (ADDRESS)
Mullen Ind. Co.
5165 Delmar Blvd.

20. FILED **FEB 28 1934**
J. Brueck
Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Feb 28, 1934*

22. I HEREBY CERTIFY, That I attended deceased from *2-22, 1934*, to *2-28, 1934*

I last saw her alive on *Feb 27, 1934*. Death is said to have occurred on the date stated above, at *4:30* A.M.

The principal cause of death and related causes of importance were as follows:

Aggranulocytic Angina (Aggranulocytosis)
Septicaemia
Ulcerative stomatitis
Date of onset *?*

Name of operation *None* Date of *None*
What test confirmed diagnosis? *blood study* Was there an autopsy? *No*

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.....

(Signed) *W. H. Riley*, M. D.
(Address) *466 Maryland*
St. Louis 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.

Dr. W. H. Riley
Bethesda Hosp
11 A.M.

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