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

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.

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

OCT 17 1934

Do not use this space.

File No. 33762
Registered No. 32

1. PLACE OF DEATH
County Platte
Township Mary
City [redacted] (No. ..... St. ..... Ward)
Registration District No. 696
Primary Registration District No. 5928

2. FULL NAME Roxie Jane Blackburn
(a) Residence. No. Fredelview Mo St., ... Ward. .....
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 2 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	Wh.	Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (OR) WIFE OF Thomas R.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 8, 1861

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	72	10	11	

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 Self.

9. BIRTHPLACE (CITY OR TOWN) Boonville
(STATE OR COUNTRY) Mo.

PARENTS

10. NAME OF FATHER Sylvester Calvert
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Mo.
12. MAIDEN NAME OF MOTHER Lucretia Bell
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Unknown

14. INFORMANT Ida James Blackburn
(Address) Fredelview Mo.

15. FILED 9/19 1934 Mrs F. E. Murrah
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept. 19 1934

17. I HEREBY CERTIFY, That I attended deceased from 8/ [illegible], 193[illegible], to 9/19/, 1934, that I last saw h[illegible] alive on 9/19/ 1934 and that death occurred, on the date stated above, at 5:30 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Myocarditis
9 21
1 19
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (SECONDARY) General debility
..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED Home
IF NOT AT PLACE OF DEATH .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) [illegible] M. D.
, 19 (Address) Smithville 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
Mt. Hope Cem K.C.Mo.	9/21/1934
20. UNDERTAKER Geo H. Long	ADDRESS K.C.Mo.