

DEC 26 1935

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

Do not use this space.

36123

1. PLACE OF DEATH

County Jackson
Township Law
City Kansas City (No. 2934 Summit)

Registration District No. 399
Primary Registration District No. 1002

File No. _____
Registered No. 4707
St. _____ Ward _____

2. FULL NAME

Orin L. Blackmon

(a) Residence, No. 2934 Summit 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 Female 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 1-7-1907
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
28 10 6

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. House Work
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. own Home
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) Arkansas13. NAME John Ball14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) South Carolina15. MAIDEN NAME Eliza Mitchell16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) South Carolina17. INFORMANT Eliza Ball
(ADDRESS) 2934 Summit St.18. BURIAL, CREMATION, OR REMOVAL
PLACE West Lawn DATE 11-16 193519. UNDERTAKER K. C. Gumb & Casket Co.
(ADDRESS) 440 State Ave.20. FILED Nov 15, 1935 M. Crow
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11-13 193522. I HEREBY CERTIFY, That I attended deceased from 11-6 1935, to 11-13 1935I last saw her alive on 11/13 1935 Death is saidto have occurred on the date stated above, at 12:00 m.

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

French Mouth

Date of onset

Other contributory causes of importance:

Hyperemesis
Gastric

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.

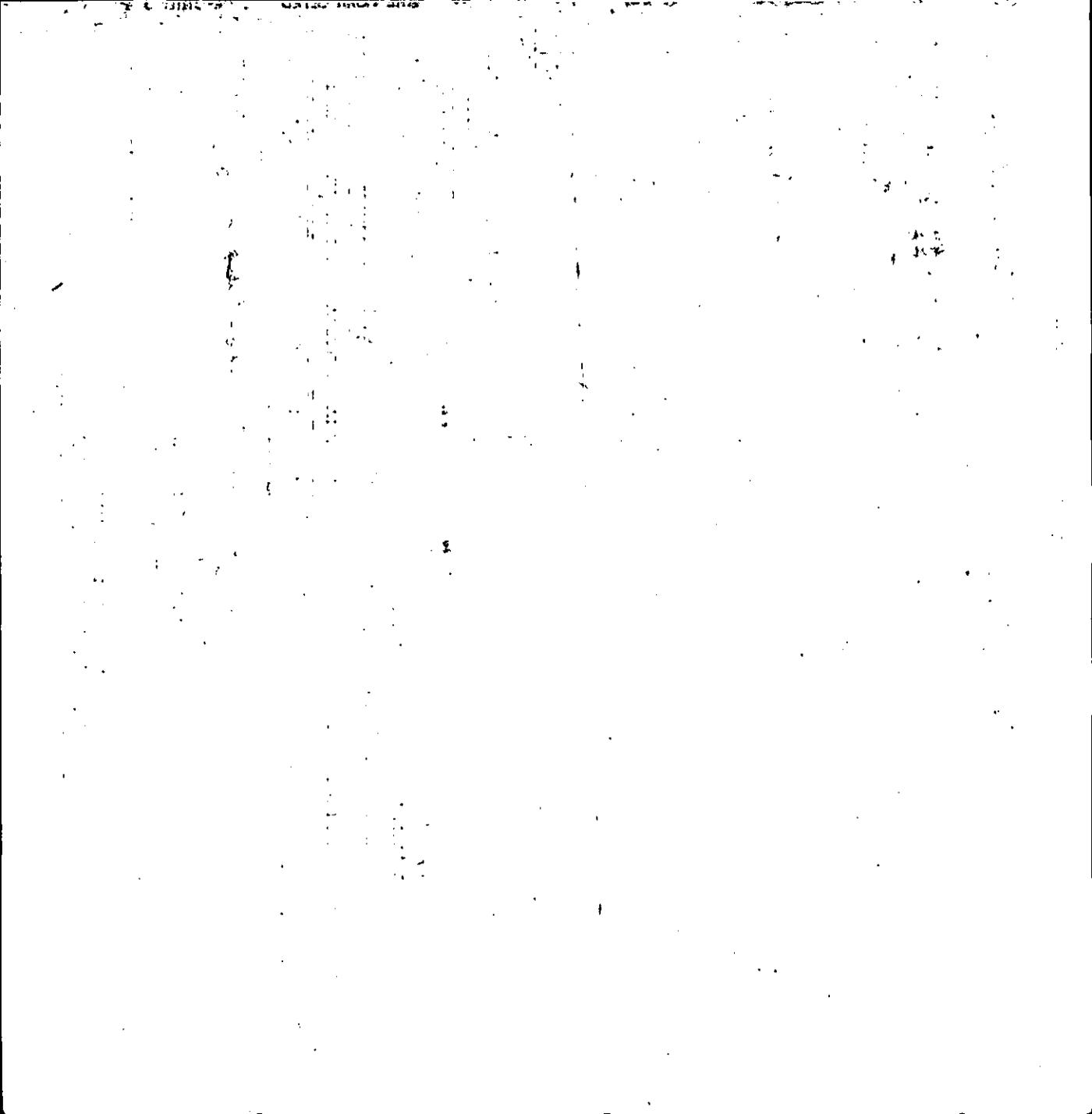
Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) J. P. Pearson M. D.(Address) 1512 25th St. S.E.



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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County..... Registration District No.....
Township..... Primary Registration District No.....
City..... (No. 2934 Summers)..... St. Ward.....

File No.....
Registered No. 4347
.....

2. FULL NAME

Orla L. Blackman

(a) Residence, No. St. Ward.....
(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 Female 4. COLOR OR RACE Col 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
28

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.....
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)

FATHER
13. NAME

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

MOTHER
15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE..... DATE..... 19.....

19. UNDERTAKER (ADDRESS)

20. FILED 11-15-1935 M. M. Brown
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 13, 1935

22. I HEREBY CERTIFY, That I attended deceased from 19....., to....., 19.....

I last saw h..... alive on....., 19..... Death is said to have occurred on the date stated above, at..... m.

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

Septicemia
Date of onset

Other contributory causes of importance:
Mercuric Iodine poisoning
Abortion due to toxemia

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?
If so, specify.....

(Signed) J. P. Mason, M. D.

(Address) 1512 9th St.

SUPPLEMENTARY

S-36123