

REC'D APR 23 1938

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

12349
Do not use this space.

1. PLACE OF DEATH *2*

(a) County *Texas* Registration District No. *887*
(b) Township *Shelby Springs* Primary Registration District No. *6138* Registered No. *14*
(c) City *Success* (d) Street No. _____ (If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME *Wayne W. Blankinship* *452*

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Single*

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Dec 16, 1928*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
9 3 4

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc. *Child*
10. Date deceased last worked at this occupation (month and year) *6* 11. Total time (years) spent in this occupation *✓*

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Success MO*

FATHER

13. NAME *Dan Blankinship*
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Hazleton MO*

MOTHER

15. MAIDEN NAME *Martha Lawson*
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Licking MO*

17. INFORMANT (ADDRESS) *Success MO*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Knalder* DATE *3/21/38*

19. FUNERAL DIRECTOR (ADDRESS) _____

20. FILED *Mar 21 1938 J. F. McDaniel*
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Mar 20* 19*38*

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to *Mar 20*, 19*38*
I last saw him alive on *Mar 20*, 19*38*. Death is said to have occurred on the date stated above, at *9 P* m.
The principal cause of death and related causes of importance were as follows:
Parasited from own dose of whiskey Date of onset _____

Other contributory causes of importance: *179-*

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? *A.C.C.A.* 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) *L. S. McDaniel*, M. D.
(Address) *Licking MO*

Julia Heenev (Licensed Embalmer's Statement on Reverse Side)

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.

STATEMENT BY LICENSED EMBALMER

I,, Licensed Embalmer No.....

hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....

..... L. E.

No..... or by....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

12349
Do not use this space.

1. PLACE OF DEATH *Texas*
 (a) County *Texas* Registration District No. *883*
 (b) Township *Lynch* Primary Registration District No. *6138* Registered No. _____
 (c) City _____ (d) Street No. _____ St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.
2. PRINT FULL NAME *Wayne Blankenship*
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *m* 4. COLOR OR RACE *w* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED *s* (circle the word)
 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.
9 3 4
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
 9. Industry or business in which work was done, as 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) _____

13. NAME _____

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

15. MAIDEN NAME _____

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

17. INFORMANT *Dan Blankenship*
 (ADDRESS) *Hazleton, Mo.*

18. BURIAL, CREMATION, OR REMOVAL
 PLACE _____ DATE _____ 19 _____

19. FUNERAL DIRECTOR *Pearl M. Dowell*
 (ADDRESS) *Hazleton, Mo.*

20. FILED *May 10 1938* *Julia Feeney*
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Mar 20 1938*

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:

Date of onset

Other contributory causes of importance: _____

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) *Leslie Randall*, M. D.

(Address) *Licking 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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

SUPPLEMENTARY

