

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

**32883**  
 Do not use this space.

DECEASED OCT 7 1938

1. PLACE OF DEATH  
 (a) County New Madrid Registration District No. 603  
 (b) Township Portage Primary Registration District No. 435-9  
 (c) City Tallipoosa (d) Street No. 5806 Registered 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 Margaret Irene Black (H-2-1)  
 (a) Residence, No. Tallipoosa 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**

**MEDICAL CERTIFICATE OF DEATH**

3. SEX Female  
 4. COLOR OR RACE white  
 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED married  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Chester Black  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 13 1938  
 7. AGE YEARS 23 MONTHS 2 DAYS 7  
 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept. 22 1938  
 22. I HEREBY CERTIFY, That I attended deceased from Sept. 15 1938 to Sept. 22 1938  
 I last saw her alive on Sept. 22 1938 Death is said to have occurred on the date stated above, at 5:05 P.  
 The principal cause of death and related causes of importance were as follows:

OCCUPATION  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife  
 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 \_\_\_\_\_

Date of onset Sept 24  
Intestinal hemorrhage due to typhoid.  
 Other contributory causes of importance: \_\_\_\_\_  
 Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? Micro Was there an autopsy? No

12. BIRTHPLACE (CITY OR TOWN) New Madrid Co., Mo  
 (STATE OR COUNTRY)

FATHER  
 13. NAME A. P. Foster  
 14. BIRTHPLACE (CITY OR TOWN) Cabb. Co. Tenn.  
 (STATE OR COUNTRY)

MOTHER  
 15. MAIDEN NAME Lillie Robinson  
 16. BIRTHPLACE (CITY OR TOWN) Harrisburg Ill  
 (STATE OR COUNTRY)

17. INFORMANT Chester Black  
 (ADDRESS) Tallipoosa, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Malden DATE Sept. 23 1938

19. FUNERAL DIRECTOR (NAME) Lander Campbell  
 (ADDRESS) \_\_\_\_\_

20. FILED 9-23 1938 Dr. W. H. Stuedel Local Registrar. 53

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) W. M. Crawford M. D.  
 (Address) Tallipoosa

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, .....

..... or by .....

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**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.)**

**If this body is not embalmed, above space should be left blank.**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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CERTIFICATE OF DEATH

32883

Do not use this space.

1. PLACE OF DEATH

(a) County New Madrid Registration District No. 605-  
 (b) Township Portage Primary Registration District No. 5806 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

Margaret Irene Blaser  
 (a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED on  
(write the word)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 15 1965

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .....hrs. or .....min.  
23 2 7

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. \_\_\_\_\_  
 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. FUNERAL DIRECTOR (ADDRESS) \_\_\_\_\_

20. FILED 11/13 1968 Dr. G. W. Luster Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 22, 1968

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) F. M. Crawford, M. D.

(Address) Parma

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

SUPPLEMENTARY

