

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

23147
Do not use this space.

JUL 14 1939

1. PLACE OF DEATH
 (a) County St. Francois 3 Registration District No. 773
 (b) Township St. Francois 1 Primary Registration District No. 60184 Registered No. 104
 (c) City Farmington (d) Street No. State Hospital No. 4 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.
 15.2

2. PRINT FULL NAME Blake E. Livingston
 (a) Residence, No. Poplar Bluff, Mo. St.
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 3-20-1883

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
56 2 26

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

FATHER
 13. NAME B. K. Livingston /
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana /

MOTHER
 15. MAIDEN NAME Linda McDaniel
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana

17. INFORMANT Records of State Hospital No. (ADDRESS) Farmington, Mo.

18. BURIAL, CREMATION, OR REMOVAL Poplar Bluff, Mo. PLACE State Hosp. #4 DATE 6-19 1939
Cemetery

19. FUNERAL DIRECTOR (NAME) Chas. Richardson (ADDRESS) Farmington, Mo.

20. FILED June 17, 1939 B. J. Robinson Local Registrar. 699 (Address) Farmington, Mo.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6-16 1939

22. I HEREBY CERTIFY, That I attended deceased from Nov. 15, 1938, to 6-16, 1939
 I last saw him alive on 6-15, 1939. Death is said to have occurred on the date stated above, at 8:15 Am.
 The principal cause of death and related causes of importance were as follows:
Paresis
1864
 Date of onset

Other contributory causes of importance:
Fr. of left femur 6-11-39

Name of operation none Date of.....
 What test confirmed diagnosis? Laboratory Was there an autopsy? yes

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? Accident Date of injury 6-11, 1939
 Where did injury occur? State Hosp. no 4
 (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury Slipped and fell on floor
 Nature of injury Fracture of left femur

24. Was disease or injury in any way related to occupation of deceased? No
 If so, specify.....
 (Signed) R. Kulaliman, M. D.

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 *Chas. Richardson*

Licensed Embalmer No. *3167*

P. O. Address *Garrington*

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.