

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.

DEPARTMENT OF COMMERCE

1939 AUG 17 1939

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 25500

Registration District No. 266

Primary Registration District No. 4164

Registrar's No. 60

1. PLACE OF DEATH:

(a) County Dent
(b) City or town Salem
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Salem, Mo.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 50 yrs. (Specify whether years, months or days)
In this community 434

3. (a) PRINT FULL NAME Julia Belle Blackwell

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife H. A. Blackwell 6. (c) Age of husband or wife if alive 75 years
7. Birth date of deceased (Month) 11 (Day) 24 (Year) 1867

8. AGE: Years 71 Months 7 Days 14 If less than one day hr. _____ min. _____

9. Birthplace Kentucky (City, town, or county) _____ (State or foreign country) _____

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER { 12. Name Robert Bowman 1
13. Birthplace Tenn. (City, town, or county) _____ (State or foreign country) _____
14. Maiden name Mary Jane Peden 1
15. Birthplace Tenn. (City, town, or county) _____ (State or foreign country) _____

16. (a) Informant's own signature H. A. Blackwell
(b) Address Salem, Mo.

17. (a) Burial (b) Date thereof 7-9-1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Dry Fork Cemetery

18. (a) Signature of funeral director W. H. T. Grantham
(b) Address Salem, Mo.

19. (a) July 8, 1939 (b) F. E. Doherty, M.D.
(Date reported local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Dent 1
(c) City or town Salem
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location) 3
(e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 8
year 1939 hour 2 A minute _____ M.

21. I hereby certify that I attended the deceased from April, 1939 to July 8, 1939
that I last saw her alive on July 7, 1939
and that death occurred on the date and year stated above.

Immediate cause of death Apoplexy Duration 1939

Due to Chronic Nephritis 1938

Due to _____

Other conditions none (Include pregnancy within 3 months of death) 181

Major findings: Of operations none

Of autopsy no

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) no
(b) Date of occurrence 7-9-1939
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work _____ (Specify type of place) (e) Means of injury stroke

23. Signature W. H. T. Grantham (M. D. or other) _____
Address Salem, Mo. Date signed _____

RECEIVED

District Health Officer No. 5,

District File Number 83912

Date Filed 8-10-39

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 me

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

Signed H. W. Johnson

Licensed Embalmer No. 928

P. O. Address Salisbury, Md.

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.