

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

32401
Do not use this space.

Cause of death in part corrected by Supplemental Report 10-1-1939 L. W. W.

OCT 9 1939

1. PLACE OF DEATH

(a) County GREENE Registration District No. 318

(b) Township SPRINGFIELD Primary Registration District No. 2001 Registered No. 695

(c) City SPRINGFIELD (d) Street No. Springfield Baptist Hospital St.

(e) Length of residence in city or town where death occurred 4 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME George J. Blankenship

(a) Residence, No. 957 S. Dollison 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 male **4. COLOR OR RACE** White **5. SINGLE, MARRIED, WIDOWED, OR DIVORCED** Married (write the word)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 22, 1891

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<input checked="" type="checkbox"/>	<u>68</u>	<u>2</u>	<u>20</u>	

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired

9. Industry or business in which work was done, as saw mill, bank, etc. Business Freight Dept

10. Date deceased last worked at this occupation (month and year) _____ **11. Total time (years) spent in this occupation** _____

12. BIRTHPLACE (CITY OR TOWN) London (STATE OR COUNTRY) Kentucky

FATHER

13. NAME James N. Blankenship

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

MOTHER

15. MAIDEN NAME Sarah Barbours

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

17. INFORMANT Mary Dec. Blankenship (ADDRESS) Springfield, Mo

18. BURIAL, CREMATION, OR REMOVAL
 PLACE Hazelwood DATE 9-13-39

19. FUNERAL DIRECTOR (NAME) Alma Schmoyer (ADDRESS) Springfield Mo

20. FILED Sept 12, 1939 Chas. A. Brown Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-12, 1939

22. I HEREBY CERTIFY, That I attended deceased from 9-9, 1939, to 9-11, 1939.

I last saw him alive on 9-11, 1939. Death is said to have occurred on the date stated above, at 3:40A m.

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

Date of onset 9-9-39

Other contributory causes of importance:
Charotic paralysis

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? No
 If so, specify: _____
 (Signed) Mary Dec. Blankenship, M. D.
 (Address) 533 E. W. Daniel

Atherton
333 E 72nd Street

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. *1767*

P. O. Address..... *Spring Field*

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

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

X

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

Do not use this space.

Mary Jean Blenkinship

1. PLACE OF DEATH: **GREENE** Registration District No. **316**
 (a) County: **GREENE** (b) Township: **SPRINGFIELD** Primary Registration District No. **2001** Registered No. **695**
 (c) City: **SPRINGFIELD** (d) Street No. **Springfield Baptist Hospital** 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: **George Thomas Blankenship**
 (a) Residence, No. **957 S. Jackson** 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: **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: **Mary Lee Blankenship**

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): **June 22, 1878**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.: **68 2 20**

OCCUPATION: 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.: **Retired**
 9. Industry or business in which work was done, as saw mill, bank, etc.: **Frisco Freight Dept**
 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): **Turner Kentucky**

FATHER: 13. NAME: **James N. Blankenship**
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): **Kentucky**

MOTHER: 15. MAIDEN NAME: **Sarah Barborow**
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): **Virginia**

17. INFORMANT (NAME) (ADDRESS): **Mrs. George J. Blankenship Springfield, Mo**

18. BURIAL, CREMATION, OR REMOVAL PLACE: **Hazelwood** DATE: **9-13-39**

19. FUNERAL DIRECTOR (NAME) (ADDRESS): **Alma Schmeyer Springfield, Mo**

20. FILED: **Oct 9 1939** **Chas. A. Berger** Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): **9-12-1939**

22. I HEREBY CERTIFY, That I attended deceased from **9-9**, 19**39**, to **9-11**, 19**39**
 I last saw him alive on **9-11**, 19**39** Death is said to have occurred on the date stated above, at **3:40 A.M.**
 The principal cause of death and related causes of importance were as follows:
Bronchial Pneumonia Date of onset **9-9-39**

Other contributory causes of importance:
Heart Paralysis

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) **Mary Jean Blenkinship** M. D.
 (Address) **345 E. No. Daniel**

Every item of information so carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CHIEF STATE Exact statement of OCCUPATION is very important.

107A

S-32401

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 with the above constitutes grounds for revocation of license.)

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

Vertical text on the right edge of the page, including "EXHIBIT" and other illegible markings.

