

JUN 17 1940

399

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

17700

State File No. _____

Registration District No. _____

Primary Registration District No. 1002

Registrar's No. 2227

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1709 Belleview
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 50 years
years, months or days)

3. (a) PRINT FULL NAME Mattie Blackman 425

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Fe 5. Color or race Col. 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Lon Blackman 6. (c) Age of husband or wife if alive 64 years

7. Birth date of deceased April 11 1886
(Month) (Day) (Year)

8. AGE: Years 54 Months 1 Days 15 If less than one day
hr. _____ min.

9. Birthplace Nashville Tenn.
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Richard Bryant

18. Birthplace Tenn.
(City, town, or county) (State or foreign country)

14. Maiden name Jensie

15. Birthplace Tenn.
(City, town, or county) (State or foreign country)

16. (a) Informant Lon Blackman

(b) Address 1709 Belleview

17. (a) burial (b) Date thereof 5/31/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Highland Cem.

18. (a) Signature of funeral director W. M. Brown

(b) Address 1729 Lydia

19. (a) May 31, 1940 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limit, write "RURAL")
(d) Street No. 1709 Belleview
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 26
1940 hour 8 minute 15 P. M.

21. I hereby certify that I attended the deceased from 5/26, 1940 to 5/26, 1940
that I last saw her alive on 5/26/40, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Hemorrhage

Due to carcinoma of mouth

Due to carcinoma of right breast

Other conditions Toxemia
(Include pregnancy within 3 months of death)

Duration

PHYSICIAN

Major findings: _____

Of operations _____

Of autopsy _____

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) _____

(b) Date of occurrence _____

(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 _____

23. Signature Dr. L. G. Wittman (M. D. or other)

Address 1618 Lydia Date signed 5/27/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

571

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.....

R. M. Adams

Licensed Embalmer No. *4116*

P. O. Address *1729 Lydia - K. C. Mo.*

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 17700
Registrar's No. 2227

Registration District No.

Primary Registration District No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

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

3. (a) PRINT FULL NAME Mattie Blackman

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

4. Sex F 5. Color or race B 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife 6. (c) Age of husband, or wife, if alive years

7. Birth date of deceased. (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day min.

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

10. Usual occupation.

11. Industry or business.

12. Name.

13. Birthplace. (City, town, or county) (State or foreign country)

14. Maiden name.

15. Birthplace. (City, town, or county) (State or foreign country)

16. (a) Informant.

(b) Address.

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

(c) Place: burial or cremation.

18. (a) Signature of funeral director.

(b) Address.

19. (a) 5/31/40 (b) M. M. Grove
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May 26 - 40
year hour minute M.

21. I hereby certify that I attended the deceased from 19....., to 19.....;
that I last saw him alive on 19.....;
and that death occurred on the date and hour stated above.

Immediate cause of death Hemorrhage -
Carcinoma of month
Carcinoma of Breast

Other conditions Typhemia 50
(Include pregnancy within 3 months of death)

Major findings: None to state
Of operations: (Primary lesion)
Of autopsy.

Duration
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)
(b) Date of occurrence
(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?
(Specify type of place)
While at work? (e) Means of injury.

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

S-17700