

Registration District No. 218

Primary Registration District No. 3015

1. PLACE OF DEATH: DEAD SEP 19 1940
(a) County COOPER
(b) City or town BOONVILLE
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: DR. ALEX RAVENSWAAY'S HOSPITAL
(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 BOBBY LEE BLANK 452
8. (b) If veteran, name war NONE 8. (c) Social Security No. NONE

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced INFANT
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased AUGUST 10 1940
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 0 0 1 hr. 0 min.

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

10. Usual occupation INFANT

11. Industry or business INFANT

12. Name HERBERT BLANK

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

14. Maiden name IVA LUCILLE WALLER

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

16. (a) Informant's own signature Herbert Blank

(b) Address Boonville MO

17. (a) BURIAL (b) Date thereof AUG. 11 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation WALNUT GROVE CEMETERY

18. (a) Signature of funeral director STEGNER & KOENIG

(b) Address BOONVILLE, MO.

19. (a) 8-10-40 (b) Stegner
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County COOPER
(c) City or town BOONVILLE
(If outside city or town limits, write "RURAL")
(d) Street No. JEFFERSON ROAD
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 10
year 1940 hour 2:00 minute _____ P. M.

21. I hereby certify that I attended the deceased from Aug 10
1940 to Aug 10, 1940
that I last saw him alive on Aug 10, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Subarachnoid Hemorrhage Duration ?

Due to Dystocia

Due to 160 lbs

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

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? 197

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature Hubrey A Wells (M. D. or other) _____

Address Boonville, Mo. Date signed 8-10-40

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.

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 9-10-40

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.