

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

34996

Do not use this space.

1. PLACE OF DEATH

(a) County Cape Girardeau Registration District No. 125
(b) Township _____ Primary Registration District No. 3009 Registered No. 361
(c) City Cape Girardeau (d) Street No. St. Francis 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

(a) Residence, No. Greenbrier, Mo. 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 Female
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Cliff Blackwell
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 28, 1900
7. AGE YEARS 40 MONTHS 3 DAYS 20 If LESS than 1 day, _____ hrs. or _____ min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housekeeper
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) Anniston, Mo.
(STATE OR COUNTRY) Mo.

13. NAME W. M. Band
14. BIRTHPLACE (CITY OR TOWN) Illinois
(STATE OR COUNTRY) Illinois

15. MAIDEN NAME Serena Jackson
16. BIRTHPLACE (CITY OR TOWN) Kentucky
(STATE OR COUNTRY) Kentucky

17. INFORMANT (ADDRESS) Harvey Band
Sturdivant, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Greenbrier, Mo. DATE Nov. 1, 1940

19. FUNERAL DIRECTOR (NAME) Glenn S. Morgan
(ADDRESS) Advance, Mo.

20. FILED 10-31 1940 J. M. Thompson
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct. 30, 1940

22. I HEREBY CERTIFY, That I attended deceased from 10-29-40 to 10-30-40, 1940
I last saw him alive on 10-30-40, 1940. Death is said to have occurred on the date stated above, at 3:45 P. M.

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

Other contributory causes of importance: NONE

Name of operation NONE 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 10/28/40

Where did injury occur? Advance, Mo.
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place: Public Place

Manner of injury Auto Acc.
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify _____

(Signed) W. Smith M. D.
(Address) Cape Girardeau

STATEMENT TO BE MADE BY THE EMBALMER
IN CONNECTION WITH THE
ISSUANCE OF A LICENSE



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, Lloyd S. Morgan, or by _____
Registered Apprentice No. _____, working under my personal supervision.

Signed

Licensed Embalmer No.

3369

P. O. Address

Advance, 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

State File No. **34996**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **125**

Primary Registration District No. **3009**

Registrar's No.

1. PLACE OF DEATH:

(a) County **Cape Girardeau**
(b) City or town **Cape Girardeau**
(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

Marnie Blackwell

3. (b) If veteran,
name war

3. (c) Social Security
No.

4. Sex **7**

5. Color or
race **W**

6. (a) Single, widowed, married,
divorced **wid**

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

40

3

25

hr 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)

(Date received local registrar)

(b)

(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 **10** day **30**
year **1990** hour minute M.

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

Immediate cause of death

Due to **Skull**
auto accident

Due to **with a collection**

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

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

(a) Accident, suicide, or homicide (specify) **accident**

(b) Date of occurrence **October 30, 1990**

(c) Where did injury occur? **advance**

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

Public place

While at work? Specify type of place

Means of injury

23. Signature **A. D. Smith** (M. D. or other)

Address **Cape Girardeau** Date signed **12/14/90**

Duration

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

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

ROWENA MOORE

