

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**

Do not use this space.

NOV 15 1940

**1. PLACE OF DEATH**

County Franklin  
 Township Cassville  
 City (No. )

Registration District No. 294  
 Primary Registration District No. 540913

File No. 35270  
 Registered No. \_\_\_\_\_  
 St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Margaret Ann Blume  
 (a) Residence, No. \_\_\_\_\_ St. \_\_\_\_\_ Ward Mercedon. Mo  
 (Usual place of abode) (If nonresident, give city or town and State)  
 Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) single  
 6A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 22, 1892  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
48

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Janitor  
 9. Industry or business in which work was done, as silk mill, 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) (STATE OR COUNTRY) Kansas

13. NAME Herman J. Blume

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

15. MAIDEN NAME Margaret Barlow

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

17. INFORMANT Miss Ella Blume (ADDRESS) St. Clair, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Old Fellows Cem. DATE Oct. 15, 1940

19. UNDERTAKER Casey & Lenox (ADDRESS) St. Clair, Mo.

20. FILED Nov. 9, 1940 M. H. Duckworth Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10 - 14 - 1940  
 22. I HEREBY CERTIFY, That I attended deceased from 7-31 - 1940 to 10 - 14 - 1940  
 I last saw him alive on 10 - 14 - 1940. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.  
 The principal cause of death and related causes of importance were as follows:

abscess of liver Date of onset ?  
ABC

Other contributory causes of importance: Chr. Myocarditis 14/20

Name of operation Chol Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? no

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) M. H. Duckworth M. D.  
 (Address) St. Clair, Mo

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MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **35270**  
Registrar's No. \_\_\_\_\_

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. **294**

Primary Registration District No. **3409B**

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

1. PLACE OF DEATH:

(a) County **Franklin**  
(b) City or town **Central T.P.**  
(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)

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.

3. (a) PRINT FULL NAME

**Margaret Ann Blume**

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

4. Sex \_\_\_\_\_ 5. Color or race \_\_\_\_\_ 6. (a) Single, widowed, married, divorced \_\_\_\_\_

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

7. Birth date of deceased **apr 22 1897**  
(Month) (Day) (Year)

8. AGE: Years **48** Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ h. \_\_\_\_\_ 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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) **10/10/60** (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **10** day **14** year **1950** hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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

Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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) \_\_\_\_\_

(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) (c) Means of injury \_\_\_\_\_

23. Signature **W. H. Duckworth** (M.D. or other) \_\_\_\_\_

Address **St. Clair** \_\_\_\_\_ Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

