

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. ....

4275

Registration District No. .... 791

Primary Registration District No. .... 1003

Registrar's No. ....

1. PLACE OF DEATH:

(a) County.....  
(b) City or town..... St. Louis, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Homer Phillips Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 10 days  
(Specify whether years, months or days)  
In this community 20 years

3. (a) PRINT FULL NAME Clark Blackwell

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

4. Sex Male 2 5. Color or race Colored 6. (a) Single, widowed, married, divorced Single

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

7. Birth date of deceased Not Known  
(Month) (Day) (Year)

8. AGE: Years About 52 Months Days If less than one day hr. min.

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

10. Usual occupation Laborer

11. Industry or business.....

MOTHER FATHER { 12. Name Lansy Blackwell  
13. Birthplace Miss.  
(City, town, or county) (State or foreign country)  
14. Maiden name Patsy Smith  
15. Birthplace Miss.  
(City, town, or county) (State or foreign country)

16. (a) Informant Patsy Smith  
(b) Address 2727 Lucas Ave.

17. (a) Burial (b) Date thereof May 15, 1942  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation National Cem. Jefferson-Barnacks

18. (a) Signature of funeral director A. L. Beal Und Co.  
(b) Address 2726 Lucas Ave

19. (a) MAY 15 1942 (b) J. F. Proctor  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County.....  
(c) City or town St. Louis,  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2700 Cole  
(If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 10,  
year 1942 hour 9 minute 30 A. M.

21. I hereby certify that I attended the deceased from April  
30, 1942, to May 10, 1942  
that I last saw him alive on May 10, 1942  
and that death occurred on the date and hour stated above.

Immediate cause of death..... Duration.....  
Pulmonary Tuberculosis Unknown

Due to.....

Due to.....

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?

While at work?..... (Specify type of place) (e) Means of injury.....

23. Signature J. W. Johnson (M. D. or other) 0  
Address 2701 Webster Date signed 5/15/42

**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.....

*Arthur L. Hilliard*

Licensed Embalmer No.....

*4221*

P. O. Address.....

*2649<sup>th</sup> Delmar Blvd*

**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, fact should be so stated above.**