

6-2
5-12
7-39
X32873

FILED MAR 20 1944

Registration District No. 101

Primary Registration District No. 5414

1. PLACE OF DEATH:

(a) County Douglas

(b) City or town Ava - Washington
(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 Missouri (b) County Douglas : 34

(c) City or town Ava Route 0
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME D. Andrew Blackburn

3. (b) If veteran, name war No

3. (c) Social Security No. None

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

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

7. Birth date of deceased April 7, 1866
(Month) (Day) (Year)

8. AGE: Years 77 Months 10 Days 2 If less than one day _____ hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER } 12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant James M. Spring

(b) Address R. Ava, Missouri

17. (a) Burial (b) Date thereof 2-10-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Arno ms

18. (a) Signature of funeral director Friends

(b) Address Arno Community

19. (a) 3-1-1944 (b) Mrs. J. R. Sparlock
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 9
year 1944 hour 12 minute 30 P. M.

21. I hereby certify that I attended the deceased from Feb 4 1944 to Feb 9 1944,
that I last saw him alive on Feb 9 1944,
and that death occurred on the date and hour stated above.

Immediate cause of death PNEUMONIA Duration _____

Due to _____

Due to _____

Other conditions Broken by ✓
(Include pregnancy within 3 months of death)

Major findings: **ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED**

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) 034

(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 D. P. Hasler 2 (M. D. or other) D.O.
Address Arno, ms Date signed Feb 23 1944

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

1656

RECEIVED

District Health Officer No: 6;

District File Number 344-390

Date Filed MAR 16 1944

Request to not have body embalmed, friends took care of body.

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 *W.B. Hutchinson*

Licensed Embalmer No. 3431

P. O. Address *Area m*

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. April
Registrar's No. _____

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County St. Charles
(b) City or town Arnold, rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution Springfield Robert Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 weeks
(Specify whether _____)
In this community 20 yr.
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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME H. Andrew Blackburn

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

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

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

7. Birth date of deceased April 7 1960
(Month) (Day) (Year)

8. AGE: Years 77 Months 10 Days 30 (If less than one day, _____ min.)

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

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)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Registrar's signature)
(Date received local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ year Feb. hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 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 Pneumonia Duration _____

Due to Broken leg.

Due to _____

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

Major findings: Of operations _____ Of autopsy _____
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
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? ava. street Douglas Mo
(City or town) (County) (State)

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

While at work? _____ (Specify type of place) (e) Means of injury fall while walk

23. Signature Dr. P. E. Harkin (M. D. or other) Dr. O

Address ava mo Date signed April 7-1960

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

SUPPLEMENTARY

18867