

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

11103

FILED APR 8 1948

State File No.

Registration District No. 188

Primary Registration District No. 5-8-29

Registrar's No. 3

1. PLACE OF DEATH:

(a) County Hickory
(b) City or town Wheatland Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Wheatland Rural
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community all of life years, months or days

3. (a) PRINT FULL NAME Elizabeth Blackwell

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

4. Sex Female 5. Color or race W 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife George Blackwell 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased 8-19-1854 (Month) (Day) (Year)

8. AGE: Years 89 Months 3 Days 9 If less than one day hr. _____ min. _____

9. Birthplace Barry Co, Mo (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

12. Name Fink Blackwell
13. Birthplace unknown (City, town, or county) (State or foreign country)
14. Maiden name Sarah Spore
15. Birthplace unknown (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Eugene B Langford
(b) Address Wheatland, Mo
17. (a) Burial (burial, cremation, or removal) (b) Date thereof 11-30-43 (Month) (Day) (Year)

(c) Place: burial or cremation Perquitage, Mo
18. (a) Signature of funeral director Robert Johnson
(b) Address Wheatland Mo

19. (a) Mr 21-44 (Date received local registrar) (b) Mary E Carlstrom (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Hickory
(c) City or town Wheatland (Rural) (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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Nov day 28 year 1943 hour two minute 45 P.M.
21. I hereby certify that I attended the deceased from 2 1940 to Nov-28 1948
that I last saw him alive on Nov-20 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Myo-Carditis

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) (a) Means of injury _____

23. Signature D S Johnston (M. D. or other) _____
Address Wheatland Mo Date signed 3-9-1948

Duration

Several years

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 7,

District File Number

Date Filed

B-44-349
4-7-44

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, fact should be so stated above.