

S. No. 2  
4-8-43  
5-17-39  
P 1 X37823

State File No. \_\_\_\_\_  
Registrar's No. 9

FILED FEB 13 1945

Registration District No. \_\_\_\_\_ Primary Registration District No. 3002

1. PLACE OF DEATH:

(a) County Andrew  
 (b) City or town Mexico Mo  
 (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 4 days  
 (Specify whether \_\_\_\_\_)  
 In this community \_\_\_\_\_  
 years, months or days \_\_\_\_\_

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Andrew  
 (c) City or town near Mextending  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_ (If rural, give location)  
 (e) Citizen of foreign country? no (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Charles Taylor Blackmore  
 (b) If veteran, L name war \_\_\_\_\_  
 (c) Social Security No. 58-09-2331

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 17  
 year 1945 hour 10 30 minute A M.

4. Sex male 5. Color or race W  
 6. (a) Single, widowed, married, divorced married  
 (b) Name of deceased's wife Mrs Blackmore  
 (c) Age of husband or wife if alive 61 years  
 7. Birth date of deceased: March 24 1881  
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jan 13 1945 to Jan 17 1945;  
 that I last saw him alive on Jan 17 1945;  
 and that death occurred on the date and hour stated above.

8. AGE: Years 63 Months 9 Days 24  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death: Cerebral Hemorrhage with Hemiplegia right of face  
 Due to Hypertension, Cardiac Vascular Disease  
 Due to \_\_\_\_\_

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

Other conditions: \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

10. Usual occupation Manager farm  
 11. Industry or business \_\_\_\_\_

Major findings: \_\_\_\_\_  
 Of operations: 93d  
 Of autopsy: \_\_\_\_\_

12. Name B. B. Blackmore  
 13. Birthplace Callaway Co Mo  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Elizabeth Nichols  
 15. Birthplace Callaway Co Mo  
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Clara Blackmore  
 (b) Address Martinsburg Mo  
 17. (a) Burial (b) Date there 1/20/45  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Bethany Baptist Church  
 18. (a) Signature of funeral director H. H. Wells  
 (b) Address Hellsville Mo  
 19. (a) Jan 17-1945 (b) Margaret N Mackie  
 (Date received local registrar) (Registrar's signature)

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 0  
 23. Signature Hairy F O'Brien (M. D. or other) \_\_\_\_\_  
 Address Maces Mo Date signed 1-17-45

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

MOTHER FATHER

RECEIVED

District Health Officer No. 10

District File Number 2-45-277

Date Filed FEB 11 1945

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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 Self

....., Registered Apprentice No. ....  
working under my personal supervision.

Signed T. B. Wells

Licensed Embalmer No. 1588

P. O. Address Hallsville 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, fact should be so stated above.**