

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. ....

FILED SEP 25 1945

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 702

1. PLACE OF DEATH:

(a) County Greene  
(b) City or town Springfield  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 452 W. Division  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution None  
In this community 76 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Isom Joel Blackwell

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife Venna Blackwell 6. (c) Age of husband or wife if alive Unknown years  
7. Birth date of deceased January 9, 1869  
(Month) (Day) (Year)

8. AGE: Years 76 Months 7 Days 24 If less than one day hr. min.

9. Birthplace Greene County, Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Street Department

11. Industry or business Street Department

MOTHER FATHER { 12. Name Joel Blackwell  
13. Birthplace Unknown Tennessee  
(City, town, or county) (State or foreign country)  
14. Maiden name Sarah Firestone  
15. Birthplace Unknown Tennessee  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Birdie Fields

(b) Address Springfield, Missouri

17. (a) Burial (b) Date thereof Sept. 5, 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Clear Creek Cemetery

18. (a) Signature of funeral director Alma Lohmeyer Funeral Home

(b) Address Springfield, Missouri

19. (a) 9-5-45 (b) B. F. Hinkle  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene 39  
(c) City or town Springfield 2  
(If outside city or town limits, write "RURAL")  
(d) Street No. 452 W. Division 1  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes No)  
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 3,  
year 1945 hour 9:10 minute A. M.

21. I hereby certify that I attended the deceased from July 6th 1945 to 9-3- 1945.  
that I last saw him alive on 8-30- 1945.  
and that death occurred on the date and hour stated above.

Immediate cause of death Alb. meningitis (nephritis) Agro.  
Duration

Due to.....

Due to.....

Other conditions None  
(Include pregnancy within 3 months of death)

Major findings: Of operations None 132

Of autopsy none

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) Not  
(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 B. F. Hinkle (M. D. or other)  
Address Bois d'Arc Date signed 9/4/45

**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..... *L. A. Rant* .....

Licensed Embalmer No. *3044* .....

P. O. Address..... *Shirley* .....

**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.**