

3.2  
8-43  
17-39  
X37823

**FILED** OCT 17 1945

Primary Registration District No. **3033**

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Laclede  
(b) City or town Lebanon  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Wallace Memorial  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2 hrs  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Laclede  
(c) City or town Falcon (Rural)  
(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 \_\_\_\_\_

MEDICAL CERTIFICATION

3. (a) PRINT FULL NAME Cora Susan Blackman

20. DATE OF DEATH: Month Aug day 30  
year 1945 hour 6 minute 45 AM

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

21. I hereby certify that I attended the deceased from April 1944  
1940 to Aug 30th 1945  
that I last saw her alive on Aug 29th 1945  
and that death occurred on the date and hour stated above.

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

Immediate cause of death Cardiac Failure Duration \_\_\_\_\_

(b) Name of husband or wife Earnest L Blackman 6. (c) Age of husband or wife if alive 64 years

7. Birth date of deceased Dec 8 1900  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
44 8 22 hr. \_\_\_\_\_ min.

Due to G. U. Adenocarcinoma

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

Due to \_\_\_\_\_

10. Usual occupation Housewife

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

11. Industry or business \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

12. Name Sam Detherage

Of autopsy \_\_\_\_\_

13. Birthplace Laclede Co. Mo.  
(City, town, or county) (State or foreign country)

22. If death was due to external causes, fill in the following:

14. Maiden name Mary Rector

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

15. Birthplace Laclede Co. Mo.  
(City, town, or county) (State or foreign country)

(b) Date of occurrence \_\_\_\_\_

16. (a) Informant Earnest L. Blackman

(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

(b) Address Falcon Mo.

(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 \_\_\_\_\_

17. (a) Burial (b) Date thereof Sept 2, 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

23. Signature W. G. Holman (M. D. or other) DO  
Address Lebanon Mo. Date signed 8/31/45

(c) Place: burial or cremation New Home

19. (a) 2-7-45 (b) Ch. H. Frankberger  
(Date received local registrar) (Registrar's signature)

163

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

MOTHER FATHER

ADDITIONAL  
SUPPLEMENTARY  
INFORMATION  
REQUESTED

PHYSICIAN  
Underline the cause to which death should be charged statistically.

Received .....

Laclede County Health Unit

File No. 9-45-120 .....

Date Filed 10/16/45 .....

**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 *Dorsey H. Howe* .....

Licensed Embalmer No. 4222 .....

P. O. Address *Lebanon 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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Nov

Registration District No. 170

Primary Registration District No. 3033

Registrar's No. \_\_\_\_\_

**1. PLACE OF DEATH:**  
 (a) County Laclede  
 (b) City or town Lebanon  
(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)

**3. (a) PRINT FULL NAME** Cora S. Blackman  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race w 6. (a) Single, widowed, married, divorced \_\_\_\_\_  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_  
 7. Birth date of deceased Dec 8 1908  
(Month) (Day) (Year)

8. AGE: Years 44 Months 8 Days \_\_\_\_\_  
(If less than one day)  
 hr. \_\_\_\_\_ min.

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

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. (c) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_  
 (b) Address \_\_\_\_\_

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

**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 \_\_\_\_\_

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month \_\_\_\_\_  
 year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
 21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_;  
 that I last saw him \_\_\_\_\_ 19\_\_\_\_;  
 and that death occurred on the date and hour stated above.  
 Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_  
 Due to Adenocarcinoma (uterine)

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)  
 Major findings: \_\_\_\_\_  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
**ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED**  
49 l

Duration \_\_\_\_\_  
**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?  
 \_\_\_\_\_  
(Specify type of place)  
 While at work? \_\_\_\_\_ (c) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
 Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

**SUPPLEMENTARY**

34050