No. 2
—8-43
5-17-39
X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED JAN 2 1946

State File No. 41460

Registration District No. 157 Primary Registration District No. 3028 Registrar's No.

1. PLACE OF DEATH:

(a) County Jasper

(b) City or town Carthage (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: McCune Brooks Hospital (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 Jasper 49

(c) City or town Carthage 1 (If outside city or town limits, write "RURAL")

(d) Street No. 3 (If rural, give location)

(e) Citizen of foreign country? 8 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Nannie Blankenship

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife William Blankenship

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

7. Birth date of deceased January (Month) 10 (Day) 1877 (Year)

8. AGE:

Years	Months	Days	If less than one day
68	11	9	hr. min.

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

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name James Williams
13. Birthplace (City, town, or county) Tenn. (State or foreign country)

MOTHER
14. Maiden name Mary Crowder
15. Birthplace (City, town, or county) Tenn. (State or foreign country)

16. (a) Informant Mrs. Claud Winford

(b) Address 510 Grant Carthage Mo.

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 12-21-45 (Month) (Day) (Year)

(c) Place: burial or cremation I.O.O.F. Monett Mo.

18. (a) Signature of funeral director Blankenship

(b) Address Monett Mo.

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 19 year 1945 hour 5 minute 00 P M.

21. I hereby certify that I attended the deceased from 12-17-45, 19, to 12-19, 1945; that I last saw her alive on 12-19, 1945; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Carcinoma of sigmoid colon	1 yr +
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy 46

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? (e) Means of injury

23. Signature W. Russell Smith (M. D. or other) M.D.

Address Carthage Mo. Date signed 12-22-45

1458 (Licensed Embalmer's Statement on Reverse Side)

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. H. Blankenship

Licensed Embalmer No. 2399

P. O. Address Monett, 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.

No. 2B
—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Jan

Registration District No. 157 Primary Registration District No. 3028 Registrar's No.

1. PLACE OF DEATH:

(a) County Jasper

(b) City or town Carthage (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: McCune Brooks Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jasper

(c) City or town Carthage (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 Nannie Blankenship

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 Wid

6. (b) Name of husband or wife

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

7. Birth date of deceased Jan 10 1877 (Month) (Day) (Year)

8. AGE: Years 68 Months 11 Days 9 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business housewife

FATHER 12. Name James Williams

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

MOTHER 14. Maiden name Mary Crowder

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

16. (a) Informant Mrs Claud Winford

(b) Address Carthage, Mo

17. (a) (Burial, cremation, or removal) (b) Date thereof 12-21-45 (Month) (Day) (Year)

(c) Place: burial or cremation 2007. Monett, Mo

18. (a) Signature of funeral director Blankenship

(b) Address Monett Mo.

19. (a) 1-30-1946 (Date received local registrar) (b) C. B. Clinton M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec Day 9 year 1945 hour minute M.

21. I hereby certify that I attended the deceased from , 19 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 Carcinoma of Sigmoid of colon

Due to 1 yr +

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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(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? (e) Means of injury

23. Signature W. Russel Smith M.D. (M. D. or other)

Address Carthage, Mo Date signed 12-22-45

SUPPLEMENTARY

41460