

FILED MAY 2 1946

Registration District No. **286**

Primary Registration District No. **59-7-8 4424**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Polk**
(b) City or town **Humansville**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **1**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **10 yrs.** years, months or days

3. (a) PRINT FULL NAME

Nelson R. Blackwell

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex **male** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **widowed**
6. (b) Name of husband or wife **Amanda Blackwell** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Feb. 9 1867**
(Month) (Day) (Year)

8. AGE: Years **79** Months **2** Days **10** If less than one day _____ hr. _____ min.

9. Birthplace **Hickory Co. Mo. 0**
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired Farmer**

11. Industry or business

12. Name **James F. Blackwell**
13. Birthplace **Unknown**
(City, town, or county) (State or foreign country)
14. Maiden name **Elizabeth Carter**
15. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Grace Phillips**
(b) Address **Humansville, Mo.**

17. (a) **Burial** (b) Date thereof **April 24, 1946**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **McCracken-Hickory Co.**

18. (a) Signature of funeral director **E. H. Crum**
(b) Address **Humansville, Mo.**

19. (a) **Apr. 25, 1946** (b) **Quella Kirkpatrick**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Polk** **84**
(c) City or town **Humansville** **0**
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location) **0**
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **19**
year **1946** month **1** minute **2** M.
21. I hereby certify that I attended the deceased from **April 20, 1946** to **April 20, 1946**
that I last saw him on **April 20, 1946**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Occlusion**
Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations **g. t. o.**
Of autopsy _____

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) **no**
(b) Date of occurrence **none**
(c) Where did injury occur? **1** (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? **4** (c) Means of injury **2 3**
23. Signature **William D. Crum** **Craver**
Address **Humansville, Mo.** Date signed **4/20/46**

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.....

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

Signed.....

E. H. Rimm

Licensed Embalmer No. *4282*

P. O. Address *Humaneyville, 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.