

No. 2  
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-17-39  
X35897

FILED JUN 5 1946 STANDARD CERTIFICATE OF DEATH

State File No. ....

Registration District No. 274

Primary Registration District No. 3052

Registrar's No. 170

1. PLACE OF DEATH:

(a) County Jeff. Co.  
(b) City or town Sedalia  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Bothwell  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 30 minutes  
(Specify whether  
In this community  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME Thomas Jefferson Black

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

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

6. (b) Name of husband or wife Rosa Black 6. (c) Age of husband or wife if 68 years

7. Birth date of deceased. may 9 1868  
(Month) (Day) (Year)

8. AGE: Years 78 Months 0 Days 19 If less than one day hr. min.

9. Birthplace Benton County Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

12. Name Alb Black

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

14. Maiden name Sarah Black

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

16. (a) Informant Mrs Roy Freeman

(b) Address Jules Okla.

17. (a) Burial (b) Date thereof May 30 - 1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Walker Cemetery

18. (a) Signature of funeral director Deser J. ...

(b) Address Tharsaw Mo

19. (a) 5-28-46 (b) Betty Yeager  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 28  
year 1946 hour 6:20 minute P M.

21. I hereby certify that I viewed the deceased from as follows  
5/28, 1946, 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. Multiple Fractures of skull  
Internal Injuries  
Due to automobile wreck

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:  
Of operations ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED  
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) accident

(b) Date of occurrence 5/28/46

(c) Where did injury occur? Foster Benton Mo  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
Highway 65  
While at work? no (Specify type of place) (e) Means of injury auto wreck

23. Signature Dr. K. T. ...

Address 229 E. ... Sedalia, Mo Date signed 5/28/46

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

MOTHER FATHER

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 6-4-46

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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.....

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

Signed.....

*John F. Reser*

Licensed Embalmer No. 4098

P. O. Address Warsaw

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.

Registration District No. 274 Primary Registration District No. 2002

1. PLACE OF DEATH:  
(a) County Pettis  
(b) City or town Sedalia  
(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 Thomas J. Block  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex M 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 May 9 1866  
(Month) (Day) (Year)

8. AGE: Years 78 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation \_\_\_\_\_

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

MOTHER FATHER  
{ 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. (a) \_\_\_\_\_ (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 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Due to Trailer Truck & Chevy Coupe in collision  
Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 5 months of death)  
Major findings: Of operations: \_\_\_\_\_  
Of autopsy: 170 27  
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? \_\_\_\_\_  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury collision

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

**SUPPLEMENTARY**

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

16486

17606