

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **9564**

FILED APR 14 1947

Primary Registration District No. **4239**

Registrar's No. **57**

1. PLACE OF DEATH:

(a) County **Jackson**
(b) City or town **Lees Summit**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
511 S. Douglas St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **74 hr** (Specify whether years, months or days)
In this community **74 hr**

3. (a) PRINT FULL NAME

John R. Blackwell Sr.

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 **Widowed**

6. (b) Name of husband or wife **Zelma Blackwell**

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

7. Birth date of deceased **Sept 28, 1872**
(Month) (Day) (Year)

8. AGE: Years **74** Months **6** Days **3** If less than one day hr. min.

9. Birthplace **Lees Summit Mo**
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired Farmer**

11. Industry or business **Farm**

12. Name **John R. Blackwell**

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

14. Maiden name **Matilda Chendall**

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

16. (a) Informant **Eldra R. Blackwell**

(b) Address **Lees Summit Mo**

17. (a) **Burial** (b) Date thereof **4-3-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Lees Summit Mo**

18. (a) Signature of funeral director **In B Langford**

(b) Address **Lees Summit Mo**

19. (a) **April 2, 1947** (b) **Donald C. Samshaw**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Jackson**
(c) City or town **Lees Summit**
(If outside city or town limits, write "RURAL")
(d) Street No. **511 So Douglas**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **1** year **1947** hour **11:02** minute **A. M.**

21. I hereby certify that I attended the deceased from **April 10, 1946** to **April 1, 1947**
that I last saw him alive on **April 1, 1947**
and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic Bronchial Pneumonia**
Due to **Fracture left femur**
Atherosclerosis
Due to **4 days**
5 years

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:

(a) Accident, suicide, or homicide (specify) **Accidental fracture**
(b) Date of occurrence **March 27, 1947**
(c) Where did injury occur? **Lees Summit Mo**
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Fell on floor in his home
(Specify type of place) (e) Means of injury **fall**

23. Signature **Clint Miller** (M. D. or other)
Address **Lees Summit Mo** Date signed **4-2-47**

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

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.....

Licensed Embalmer No.....

P. O. Address.....

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.