

S. No. 2
4-12-45
7-5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **15928**
Registrar's No. **914**

FILED APR 28 1947
Registration District No. **2137**

Primary Registration District No. **6076**

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

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town St. Louis General
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
ROBERT KOCH Hosp. Koch Mo. O
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 29 DAYS
(Specify whether years, months or days) 5 YEARS

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County 00-11
(c) City or town St. Louis
(If outside city or town limits, write "RURAL") 17
(d) Street No. 1025A ARMSTRONG 9
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No) 1
If yes, name country _____

3. (a) PRINT FULL NAME CALLIE BLACKMAN
3. (b) If veteran, name war No
3. (c) Social Security No. No. N.O.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month APR day 19 year 1947 hour 1:15 minute P M.
21. I hereby certify that I attended the deceased from 3-21 1947 to 4-19 1947; that I last saw her alive on 4-19 1947; and that death occurred on the date and hour stated above.

4. Sex FEMALE 5. Color or race COLORED
6. (a) Single, widowed, married, divorced SINGLE
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: 12-2-35
(Month) (Day) (Year)

Immediate cause of death _____
Pulmonary Tuberculosis
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: _____
Of operations _____
Of autopsy _____

8. AGE: Years Months Days If less than one day
11 4 17 hr. min.

Duration about 1 yr
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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

10. Usual occupation STUDENT
11. Industry or business _____
12. Name ODELL BLACKMAN
13. Birthplace ARK
(City, town, or county) (State or foreign country)
14. Maiden name ANNA LEE BURRNS
15. Birthplace ARK
(City, town, or county) (State or foreign country)

16. (a) Informant ROBERT KOCH HOSPITAL RECORD
(b) Address Koch, Mo.
17. (a) Burial (b) Date thereof Apr 24, 1947
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Washington Park
18. (a) Signature of funeral director Engle's Und. Co
(b) Address 2931 Lucas, ave
19. (a) 4-23-47 (b) Carl A. Sharp
(Date received local registrar) (Registrar's signature)

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 _____
23. Signature Koch (M. D. or other) mo
Address Koch Mo Date signed 4-20-47

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 Burton English
Licensed Embalmer No. 4208
P. O. Address 2931 Lucas, ave

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: