

S. No. 2
DM-2-43
5-17-39
X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38013

State File No. _____

FILED NOV 24 1947/49

Primary Registration District No. 1002

Registrar's No. 4768

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

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Jackson City
(c) Name of hospital or institution Research Hospital
(d) Length of stay: In hospital or institution 90 days
In this community years, months or days 1

3. (a) PRINT FULL NAME Clark Blackman
3. (b) If veteran, name war No
3. (c) Social Security No. No

4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced, widowed
(b) Name of husband or wife Clara Blackman
6. (c) Age of husband or wife if alive 22 years
7. Birth date of deceased 7-22-1883

8. AGE: Years 64 Months 3 Days 22 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business Farming

12. Name Wm A. Blackman

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

14. Maiden name Sarah Frances Rensch

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

16. (a) Informant Mrs Ruth Roberts

(b) Address Hannsburick Mo

17. (a) Removal (b) Date thereof 11/14/47

(c) Place: burial or cremation Hannsburick Mo

18. (a) Signature of funeral director Stone, McClellan

(b) Address 19 ans on city W Mo

19. (a) 11-15-47 (b) Geraldine Holmes

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Chautauq
(c) City or town Hannsburick Mo
(d) Street No Rural
(e) Citizen of foreign country? no
If yes, name country

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month NOV day 13 year 1947 hour 3 minute 15 P.M.
21. I hereby certify that I attended the deceased from 3 1947 to 11-13 1947
that I last saw him alive on 11-13 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Circulatory failure
Duration

Due to Post Operative Trauma of Prostatic Resection

Due to
Other conditions Hypertension

Major findings: Of operations 378
Of autopsy not done
PHYSICIAN

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?
(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 J. E. Mullan (M. D. or other)
Address 1019 Prof Bldg Iowa City Mo Date signed 11-15-47

*Mr. J. C. Sheppard
Professional Embalmer*

DEC 9 1949

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 *J. Clair Sheppard*.....

Licensed Embalmer No. *4179*.....

P. O. Address *K. C. 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.