S. No. 2
11-10-39
5-17-39
X21492

30301

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 13 1948

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 181 Primary Registration District No. 4293 Registrar's No. 29

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

1. PLACE OF DEATH:

(a) County LINCOLN

(b) City or town ELSBERRY
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: S. FOURTH ST.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County LINCOLN

(c) City or town ELSBERRY
(If outside city or town limits write "RURAL")

(d) Street No. S. FOURTH ST.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years

3. (a) PRINT FULL NAME ROBERT JUNIOR BLAIR

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male

5. Color or race Negro

6. (a) Single, widowed, married, divorced

6. (b) Name of husband or wife

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

7. Birth date of deceased AUG (Month) 12 (Day) 1948 (Year)

8. AGE: Years | Months 1 | Days 22 | If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER 12. Name ROBERT L. BLAIR

FATHER 13. Birthplace ELSBERRY (City, town, or county) Mo (State or foreign country)

MOTHER 14. Maiden name DOROTHY POWELL

MOTHER 15. Birthplace AUBURN (City, town, or county) Mo (State or foreign country)

16. (a) Informant mother

(b) Address ELSBERRY

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 10-4-48 (Month) (Day) (Year)

(c) Place: burial or cremation AUBURN, Mo.

18. (a) Signature of funeral director [signature]

(b) Address ELSBERRY, Mo.

19. (a) (Date received local registrar) (b) T. A. Dwyer (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCT day 4 year 1948 hour minute A. M.

21. I hereby certify that I attended the deceased from OCT 3, 1948, to OCT 4, 1948; that I last saw him alive on OCT 3, 1948; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: DEHYDRATION	2 DAYS
Due to: PYLORIC STENOSIS — CONGENITAL	LIFE
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations:	
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)

(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? (Specify type of place)

While at work? (e) Means of injury

23. Signature [signature] (M. D. or other) MD

Address ELSBERRY, MO Date signed 10/5/48

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Division Office No. 9
OCT 11 1948

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. 4012

P. O. Address Elsberry, 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, above space should be left blank.

No. 2B
M—3-45
1 X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Not

Registration District No. 181 Primary Registration District No. 4293 Registrar's No. 29

1. PLACE OF DEATH:

(a) County Lincoln

(b) City or town Elsberry
(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)

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

3. (a) PRINT FULL NAME Robert J. Blair

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race B

6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife

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

7. Birth date of deceased Aug 12 1948
(Month) (Day) (Year)

8. AGE: Years | Months | Days | If less than one day hr. min.

9. Birthplace (City, town, or county) N/C (State or foreign country)

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) Oct 5 1948 (Date received local registrar) (b) Mrs. L. A. Dwyer (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month day year hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
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)

(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?
(Specify type of place)
While at work? (e) Means of injury

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

SUPPLEMENTARY

S-30301