

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. 36053

FILED DEC 6 1948

Registration District No. 700

Primary Registration District No. 5386

Registrar's No. 72

1. PLACE OF DEATH:

(a) County Dent

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

(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community Life Time
years, months or days

3. (a) PRINT FULL NAME James H. Blackwell

3. (b) If veteran, name war ✓

3. (c) Social Security No. None

4. Sex M D 5. Color or race W

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

6. (b) Name of husband or wife Ollie Blackwell

6. (c) Age of husband or wife if alive 81 years

7. Birth date of deceased Feb 4 1864
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>84</u>	<u>9</u>	<u>18</u>	hr. min.

9. Birthplace Dent County Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

MOTHER FATHER

12. Name John Smith Blackwell

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

14. Maiden name Sarah Kincaid

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

16. (a) Informant Rosie Grace

(b) Address Edwardsville Ill.

17. (a) Burial (b) Date thereof 11-24-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Blackwell Cemetery

18. (a) Signature of funeral director Hobson & Lintner

(b) Address Salem Missouri

19. (a) Nov 23-48 (b) M. M. Hart M.D.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dent

(c) City or town Rural Norman Township
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 22
year 1948 hour 8 minute 30 A.M.

21. I hereby certify that I attended the deceased from 4-30-48, 1948, to 11-15-48, 1948.

that I last saw him alive on 11-15-48 and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerotic heart disease

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy 9.58

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 work) (e) Means of injury _____

23. Signature Salem Mo. (M. D. or other) _____

Address _____ Date signed 11/23/48

RECEIVED 11-29-48
District Health Officer No. 5,
District File Number 1148728
Date Filed 11-29-48

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..... *Edward F. Bryles*

Licensed Embalmer No. *4553*

P. O. Address. *Salem 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.