

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 11900

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. 3006		Registrar's No. 126	
1. PLACE OF DEATH a. COUNTY <u>Boone</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Knox</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>Columbia</u>		c. LENGTH OF STAY (In this place) <u>2 years</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Cairo</u>		d. STREET ADDRESS (If rural, give location) <u>None</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>505 Rogers</u>				d. STREET ADDRESS <u>None</u>			
3. NAME OF DECEASED (Type or Print)		a. (First) <u>MARY</u>		b. (Middle) <u>E</u>		c. (Last) <u>BLACKWELL</u>	
4. DATE OF DEATH (Month) (Day) (Year) <u>April-22-1950</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	
8. DATE OF BIRTH <u>Oct-18-1865</u>		9. AGE (In years last birthday) <u>84</u>		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>4</u>		11. IF UNDER 24 HRS. Hours <u>4</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Monroe Co. Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13a. FATHER'S NAME <u>Curtis Trussell</u>		13b. MOTHER'S MAIDEN NAME <u>Jane Ellison</u>		14. NAME OF HUSBAND OR WIFE <u>George R. Blackwell</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Harvey Reynolds</u> ADDRESS <u>Cairo Mo.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myocardial Decompensation</u> ANTECEDENT CAUSES <u>Hist. Malnutrition 1 wk.</u> <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> <u>Senile debility</u> <u>Hist. of 4/18/ to 4/22/50</u> <u>Phlebitis genl. to right leg</u> II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u> <u>4/22/50</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4/21 to 4/22/50</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ m. _____		21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>4/21</u> , 19 <u>50</u> , to <u>4/22</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>4/21</u> , 19 <u>50</u> , and that death occurred at <u>9:45a</u> m., from the causes and on the date stated above.							
23a. SIGNATURE <u>Walter J. ...</u> (Degree or title) _____		23b. ADDRESS <u>311 Christian Col. Ave. Columbia, Mo.</u>		23c. DATE SIGNED <u>4/22/50</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>April-24-50</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Grand Prairie</u>		24d. LOCATION (City, town, or county) (State) <u>Cairo Mo.</u>	
DATE REC'D BY LOCAL REG. <u>April 22 1950</u>		REGISTRAR'S SIGNATURE <u>Mrs. R.E. Palmer</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Snow Funeral Home</u> ADDRESS <u>Proberly Mo</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

District File Number

District Health Officer No. 9

RECEIVED APR 25 1950

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed R. M. Carter

Signed _____
Student Embalmer

Licensed Embalmer No. 4117

P. O. Address Proberly Mrs

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.