

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 31275

FILED OCT 10 1950

BIRTH NO.		REG. DIST. NO. 274		PRIMARY REG. DIST. NO. 3052		Registrar's No. 312	
1. PLACE OF DEATH a. COUNTY Pettis				2. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a. STATE Mo. b. COUNTY Benton			
b. CITY (If outside corporate limits, write RURAL and give township) Sedalia		c. LENGTH OF STAY (in this place) 1-22		c. CITY (If outside corporate limits, write RURAL and give township) Warsaw		0081	
d. FULL NAME OF (If not in hospital or institution, give street address and location) Bothwell Mem. Hosp.				d. STREET ADDRESS (If rural, give location) Walnut Grove Community			
3. NAME OF DECEASED (Type or Print)		a. (First) John		b. (Middle) William		c. (Last) Blackwell	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Apr 20, 1868	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Benton Co, Missouri		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Harm Blackwell		13b. MOTHER'S MAIDEN NAME Sina Proctor		14. NAME OF HUSBAND OR WIFE Mrs Zenith Blackwell			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. No		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs Zenith Blackwell, Warsaw			
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) Chronic Myocarditis - Decompensated ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arterio Sclerosis - Advanced DUE TO (c) Diabetes II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Secondary Anemia				INTERVAL BETWEEN ONSET AND DEATH Over 10 days ? ?	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION Medical treatment only.				20. AUTOPSY? YES ☐ NO ☒	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) None		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Warsaw Mo. 4221			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) None		21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Sept 30, 1950, to Oct 1, 1950, that I last saw the deceased alive on Oct 1, 1950, and that death occurred at 3:50 p.m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Jho B. Carline M.D.				23b. ADDRESS Sedalia Mo.		23c. DATE SIGNED Oct 1 1950	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 10-4-1950		24c. NAME OF CEMETERY OR CREMATORY Brimfield		24d. LOCATION (City, town, or county) (State) Warsaw Mo.	
DATE REC'D BY LOCAL REG. 10-4-1950		REGISTRAR'S SIGNATURE R. Campbell M.D.		25. FUNERAL DIRECTOR'S SIGNATURE R. Campbell		ADDRESS Warsaw	

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED 10-9-50

DISTRICT HEALTH OFFICE No. 3

District File Number _____

Date Filed 10-9-50

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.

Student
Student Embalmer

Signed _____

Licensed Embalmer No. 4643

P. O. Address Warsaw, 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.