

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-014346

STATE FILE NUMBER

FILED APR 27 1959

Registration District No. 274

Primary Registration District No. 3052

Registrar's No. 135

1. PLACE OF DEATH a. COUNTY <u>PETTIS</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>PETTIS</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SEDALIA</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>HOUSTONIA</u> <u>0800</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>CAMPBELL REST HOME</u>		Length of stay in lb <u>3 Mo.</u>	d. STREET ADDRESS (If outside, give location) <u>R.F.D # 1</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>JOSIAH</u> Middle <u>WEE</u> Last <u>BLACKBURN</u>			4. DATE OF DEATH Month <u>4</u> Day <u>19</u> Year <u>1959</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-12-1870</u>	9. AGE (In years last birthday) <u>89</u>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GENERAL AGRICULTURE</u>		11. BIRTHPLACE (City and state or country) <u>SHELBY Co. Mo.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>JAMES W^m BLACKBURN</u>			
13b. MOTHER'S MAIDEN NAME <u>MARY SIMPSON</u>		14. NAME OF HUSBAND OR WIFE <u>KATE SCHONDELMAIER.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>497-42-6180</u>		17. INFORMANT Address <u>JAMES BLACKBURN- HOUSTONIA Mo</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>332 X</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <u>2 d.</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>4-16-59</u> to <u>4-19-59</u> and last saw ^{him} alive on <u>4-18-59</u> Death occurred at <u>1145 A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Clavin L. Lowe M.D.</u> (Degree or title)			22b. ADDRESS <u>Sedalia, Mo</u>		22c. DATE SIGNED <u>4-20-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>4-21-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>HOUSTONIA CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>HOUSTONIA Mo</u>
24. FUNERAL DIRECTOR <u>Paul M. Moore</u> ADDRESS <u>La Monte Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>4-20-1959</u>		26. REGISTRAR'S SIGNATURE <u>Frances Shelby</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

never certify any case unless you are certain that the cause of death is as stated. All diseases in Part I must be causally related.

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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
Signature of Student Embalmer

Signed Paul M. Moore

Licensed Embalmer No. 3923

P. O. Address P. Monte 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.