

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-022080

FILED JUL 13 1959

Registration District No. L&T 179 Primary Registration District No. 5667 Registrar's No. 60

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Lincoln</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Pike</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Bedford Twp.</u>			Length of stay in 1b <u>10 Min</u>		c. CITY OR TOWN <u>Clarksville</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Lincoln Co. Hospital</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Robert Hill</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Donald Leroy Blackwell</u>				4. DATE OF DEATH Month Day Year <u>July 2, 1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 19, 53</u>	9. AGE (last birthday) <u>6</u>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (City and state or country) <u>Louisiana, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>James Edward Blackwell</u>			13b. MOTHER'S MAIDEN NAME <u>Rosemary Treese</u>			14. NAME OF HUSBAND OR WIFE <u>*****</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>None</u>		17. INFORMANT Address <u>James E. Blackwell, Clarksville, 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>Fractured Skull (Multiple)</u> DUE TO (b) <u>Ran over by tractor</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>30Mh</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <u>Child was riding in Highlift on front of</u>					
20c. TIME OF INJURY Hour Month, Day, Year <u>10:20 a.m. 7/2/59</u>		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Farm</u>					
20e. CITY, TOWN, OR LOCATION <u>Lincoln</u>		20f. COUNTY STATE <u>Mo</u>					
21. I attended the deceased from _____, to _____ and last saw him alive on _____. Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Joseph J. Marshall</u> (Degree or title) <u>CORONER</u>				22b. ADDRESS <u>351 Monroe St. Troy, Mo.</u>		22c. DATE SIGNED <u>7/2/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>July 5, 1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Clarksville, Missouri</u>	
24. FUNERAL DIRECTOR <u>Carroll Collier, Clarksville, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>7-5-1959</u>		26. REGISTRAR'S SIGNATURE <u>Charlotte Leek</u>			

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer \_\_\_\_\_

Signed

*Geo. M. Callee*

Licensed Embalmer No. *383*

P. O. Address *Louisiana*

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.