MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space. Walker

1. PLACE OF DEATH
County Henry Registration District No. 347 File No. 33569
Township Primary Registration District No. 3018 Registered No. 129
City Clinton (No. ..... St. ..... Ward)

2. FULL NAME Francis Malinda Blakemore

(a) Residence. No. 103 So 3rd St., ... Ward.
(Usual place of abode)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
F	White	Widowed

5a. IF MARRIED, WIDOWED OR DIVORCED, HUSBAND OF (OR) WIFE OF Geo Henry Blakemore

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 2-9-1844

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	85	6	3	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) Howard County Missouri
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Nathaniel Ragland
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Kentucky
12. MAIDEN NAME OF MOTHER Fannie Dunnenberg
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Monroe
(STATE OR COUNTRY) Kentucky

14. INFORMANT Fannie Blakemore
(Address) Clinton Mo

15. FILED 10-14-1929 Dr. E. C. Peelor M.C. REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10-12 1929

17. I HEREBY CERTIFY, That I attended deceased from January, 19.29, to Oct 12, 19.29 that I last saw h.. alive on Oct 11, 19.29, and that death occurred, on the date stated above, at 10 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Hypostatic Pneumonia
108
8 D

(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (SECONDARY) Senility

(duration) ..... yrs. 6 mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED .....
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) H. E. Sutherlin, M. D
10-12, 1929 (Address) Clinton Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Englewood — DATE OF BURIAL 10-15 1929

20. UNDERTAKER Sutton Wilkinson & Co — ADDRESS Clinton Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be very particular in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
County Henry — Registration District No. 347 — File No.
Township — Primary Registration District No. 3018 — Registered No. 127
City Clinton (No. , St. Ward)

2. FULL NAME Frances Malinda Blakemore

(a) Residence. No. St., Ward. (If nonresident, give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
F	W	wid

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY)

14. INFORMANT
(Address)

15. FILED Oct 14 1929 Dr. E. C. Peelor REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 12 1929

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..... to ....., 19.....
that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at ....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Hypostatic Pneumonia
Lobar pneumonia

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (SECONDARY) Paralysis, dont what kind

(duration) ....yrs. ....mos. ....ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) ....., M. D.
....., 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Englewood Cem.	10-15 1929
20. UNDERTAKER	**ADDRESS**
Sims-Wilkinson	Clinton

SUPPLEMENTARY

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN is about CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very im...

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY

5-33569