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

Do not use this space.

30347

File No. [illegible]

Registered No. [illegible]

1. PLACE OF DEATH

County: Jackson — Registration District No.: 399

Township: Kan — Primary Registration District No.: 1097

City: K. C. Mo (No. Old City Hospital St. Ward)

2. FULL NAME Blekley, Carmelia

(a) Residence. No. 3031 Front St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 11 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	Wh.	Divorced

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unk 1885

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ...min.
42.				

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

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

PARENTS

10. NAME OF FATHER Bagley Hill

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Mary Young Blood

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Okla
(STATE OR COUNTRY)

14. INFORMANT Clarence Bent
(Address) 1512 East 31st

15. FILED 10/12, 1927 M. M. Crowe Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10-3 1927

17. I HEREBY CERTIFY, That I attended deceased from 6-20, 1927, to 10-3, 1927 that I last saw h. alive on 10-3, 1927 and that death occurred, on the date stated above, at 11:50 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Hemorrhage

17A

17B

17C (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Myocarditis chronic Kidney with Uremia & Pneumonia T.B. (duration) yrs. 5 mos. — ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? Unknown

DID AN OPERATION PRECEDE DEATH? No DATE OF —

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? None.

10/4, 1927 (Signed) H. M. Smith, M.D.
(Address) Old City Hospital

*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: Blue Ridge Lawn — DATE OF BURIAL: 10-12, 1927

20. UNDERTAKER: Watkins Bros — ADDRESS: 1129 Lydia

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

THIS IS A PERMANENT RECORD

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 ..... Registration District No. 399 File No. .....

Township ..... Primary Registration District No. 1002 Registered No. 3853

City Kansas City (No. ....., ... St. ..... Ward)

2. FULL NAME Carmelia Blekler

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

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	C -	D -

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. X FILED 10/12 1927 M. M. Crowd
Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 3 - 1927

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:
Pulmonary hemorrhage
X Incipient T. B.
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) myocarditis acute pleurisy with effusion (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 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

N. B.—Every item of information should ... ...LY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that ... may b... ...dy classi... Exact statement of OCCUPATION is very important.

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

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