

JUN 5 1929

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

Do not use this space.
9.0.7 Moore
17818
File No. _____
Registered No. 351
St. _____ Ward)

1. PLACE OF DEATH

County Greene Registration District No. 318
Township _____ Primary Registration District No. 2001
City Springfield (No. 619 E Madison)

2. FULL NAME Joseph A. Blankenship

(a) Residence No. 619 E Madison 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 9-1843

7. AGE YEARS MONTHS Days If LESS than 1 day, hrs. or min.
85 9 28

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None
(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) Tenn.

10. NAME OF FATHER Wm J. Wider

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

12. MAIDEN NAME OF MOTHER _____

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

14. INFORMANT J. H. Franch
(Address) Springfield Mo.

15. FILED 5-8 1929 Wm Sharp REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-7 1929

17. I HEREBY CERTIFY, That I attended deceased from Feb 7 1929, to May 7 1929, that I last saw her alive on May 7 1929, and that death occurred, on the date stated above, at 6:53 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: A

Carcinoma Liver
465 (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) 44B
(duration) yrs. mos. da.

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? Clinical
(Signed) J. O. Moore M.D. M. D.
5-8 1929 (Address) Springfield 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 Walnut Grove DATE OF BURIAL 5-8 1929

20. UNDERTAKER Alma Schmeyer ADDRESS 534 S Main

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.

26
2
2
31

278