

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

Do not use this space.

'SEP 26 1935'

27417

**1. PLACE OF DEATH**

County *Hickman*

Registration District No. *711*

Township *Bismarck*

Primary Registration District No. *4462*

City *Bismarck Mo.*

File No. ....

Registered No. ....

St. .... Ward)

**2. FULL NAME**

*Jules Bladdick*

(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 *7* yrs. .... mos. .... ds. How long in U.S., if of foreign birth? yrs. .... mos. .... ds.

**PERSONAL AND STATISTICAL PARTICULARS**

**3. SEX**

*Male*

**4. COLOR OR RACE**

*White*

**5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)**

*married*

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

*Nellie Lester*

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

*Oct 10 1877*

**7. AGE**

YEARS *57*

MONTHS *10*

DAYS *14*

IF LESS than 1 day, .... hrs. or .... min.

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work

*Farmer*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

**9. BIRTHPLACE (CITY OR TOWN)**

*Lithuania*

(STATE OR COUNTRY)

**10. NAME OF FATHER**

*L. W. Bladdick*

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

*Lithuania*

(STATE OR COUNTRY)

**12. MAIDEN NAME OF MOTHER**

*Nellie Chukonaka*

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

*Hungary*

(STATE OR COUNTRY)

**14.**

INFORMANT

(Address)

*Felix Bladdick  
Bismarck Mo.*

**15.**

FILE

*8-26 1935 F. W. Gale MD*

REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)**

*Aug 24 1935*

**17.**

I HEREBY CERTIFY, That I attended deceased from *July 11*, 19*35*, to *Aug 24*, 19*35* (that I last saw *alive* on *Aug 24*, 19*35*, and that death occurred, on the date stated above, at *1:00* P. M.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

*Apoplexy*

(duration) *1* mos. *14* ds.

**CONTRIBUTORY (SECONDARY)**

*Hypertension*

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

**18. WHERE WAS DISEASE CONTRIBUTED?**

*Demate City Ill*

IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? *no* DATE OF

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS?

*Swelling & pouring blood*

(Signed) *Edward M. Coff*, M. D.

*8-24 1935 (Address) Bismarck 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**

**DATE OF BURIAL**

*Bismarck Mo*

*8-26 1935*

**20. UNDERTAKER**

*White & Hill*

**ADDRESS**

*Bismarck Mo*

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.

