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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **32740**

FD SEP 17 1943

Registration District No. **2**

Primary Registration District No. **6112**

Registrar's No. **No.**

1. PLACE OF DEATH:

(a) County **Scott**
(b) City or town **CHAFFEE Rural**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community **WIFE 1** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **SCOTT**
(c) City or town **ORAN**
(If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? **No.** (Yes or No)
If yes, name country.

3. (a) PRINT FULL NAME **THOMAS FRANKLIN BLOCKER**

3. (b) If veteran, name war 3. (c) Social Security No.

4. Sex **MALE** 5. Color or race **WHITE**
6. (a) Single, widowed, married, divorced **WIDOWED**
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years

7. Birth date of deceased **MAY 27 1860**
(Month) (Day) (Year)

8. AGE: Years **83** Months **2** Days **10**
If less than one day hr. min.

9. Birthplace **Benton Mo** (City, town, or county) (State or foreign country)

10. Usual occupation **FARMER.**

11. Industry or business

MOTHER FATHER { 12. Name **James Blocker**
13. Birthplace **Benton - Mo** (City, town, or county) (State or foreign country)
14. Maiden name **Mary Waley**
15. Birthplace **Benton Mo** (City, town, or county) (State or foreign country)

16. (a) Informant (b) Address

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director **P. J. Hesserer Co**

(b) Address **Oran Missouri**

19. (a) **8** - **12** (Date received local registrar) (b) **Christa Grace** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **AUG** day **7** year **1943** hour **7** minute **0** P. M.

21. I hereby certify that I attended the deceased from **June** 1943 to **Aug 7** 1943 that I last saw him alive on **Aug 7** 1943 and that death occurred on the date and hour stated above.

Immediate cause of death: **Respiratory and Cardiac Failure**
Due to **Cardio Vascular Disease 5 yrs**
Due to **Chronic Nephritis Interstitial 5 yrs**
Arterial Sclerosis
Other conditions: **Hyper tension**
(Include pregnancy within 3 months of death)

Duration **1.5 yr**

Major findings: **13/0**
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

23. Signature **W. J. Jones** (M. D. or other) **8/14/43**
Address **Oran, Mo** Date signed

1320 (Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Office No. 2,

District File Number 943-112

Date Filed 9-13-43

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.
working under my personal supervision.

Signed.....

Raymond Crews

Licensed Embalmer No. 3467

P. O. Address Sikeston, Mo.

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 this body is not embalmed, fact should be so stated above.

Registration District No. 228 Primary Registration District No. 6112

1. PLACE OF DEATH:
(a) County Scott
(b) City or town Rural Kelso Sup
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community Life years, months or days) _____ (Specify whether

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Scott
(c) City or town _____
(d) Street No. Kelso Township
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Thomas J Blocker
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Aug year 1943 hour 3:30 minute P.M.
21. I hereby certify that I attended the deceased from June - 1940
that I last saw him alive on Aug 7, 1943
and that death occurred on the date and hour stated above. 1943
Immediate cause of death Respiration and Cornea failure one
day Duration 5 year

4. Sex M 5. Color of race W 6. (a) Single, widowed, married, divorced W
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
alive _____ years
7. Birth date of deceased May 27 (Month) (Day) (Year)

Due to Cardio Vascular Pain Disease
Chronic Nephritis Intestinal
Due to Chronic Myocarditis
Other conditions Hepper Duoden
(Include pregnancy within 5 months of death)

8. AGE: Years 83 Months 2 Days 16 min. 10
9. Birthplace Benton Mo. (City, town, or county) (State or foreign country)
10. Usual occupation Farmer

Major findings:
Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

11. Industry or business _____
12. Name James Blocker
13. Birthplace Benton Mo. (City, town, or county) (State or foreign country)
14. Maiden name Mary Wiley
15. Birthplace Benton Mo. (City, town, or county) (State or foreign country)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? _____ (Specify type of place) (e) Means of injury _____

16. (a) Informant Grover Blocker
(b) Address Lickston Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-9-43 (Month) (Day) (Year)
(c) Place: burial or cremation Memorial Park, C. Cape, Mo.
18. (a) Signature of funeral director J. H. Hessemer & Co
(b) Address Oran Mo.
19. (a) 8-12-43 (Date received local registrar) (b) Christa Grover (Registrar's signature)

23. Signature Dr. W. J. Finney (M. D. or other)
Address La Paffee Mo. Date signed 8/19/43

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTAL

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