

1. PLACE OF DEATH: Cape Girardeau
 (a) County: _____
 (b) City or town: Rural Grand Jury
 (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: 12 years
 years, months or days)

3. (a) PRINT FULL NAME: SIEBERT BLOCKER
 (b) If veteran, name war:
 (c) Social Security No.: _____

4. Sex: male 5. Color or race: white
 6. (a) Single, widowed, married, divorced, single
 (b) Name of husband or wife: _____ (c) Age of husband or wife if
 alive: _____ years
 7. Birth date of deceased: Oct 18 - 1883
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
60 2 19 hr. min.

9. Birthplace: Oran Mo
 (City, town, or county) (State or foreign country)

10. Usual occupation: Farmer

11. Industry or business: _____

MOTHER FATHER
 12. Name: William Blocker
 13. Birthplace: Oran Mo
 (City, town, or county) (State or foreign country)
 14. Maiden name: Mrs. Calhoun
 15. Birthplace: Oran Mo
 (City, town, or county) (State or foreign country)

16. (a) Informant: E. Eugene Galt
 (b) Address: E. Mahall P. St.

17. (a) _____ (b) Date thereof: Jan 10 - 1944
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Lesley Cemetery

18. (a) Signature of funeral director: W. Miller

(b) Address: Jackson mo

19. (a) Jan 10 - 44 (b) J. H. Keener
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State: Missouri (b) County: Cape Girardeau
 (c) City or town: Rural
 (If outside city or town limits, write "RURAL")
 (d) Street No.: _____ (If rural, give location)
 (e) If foreign born, how long in U. S. A.: 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 7
 year 1944 hour 11 minute 30 P.M.

21. I hereby certify that I attended the deceased from Sept
1943 to Jan 1, 1944
 that I last saw him alive on Jan 1, 1944
 and that death occurred on the date and hour stated above.

Immediate cause of death: Pulmonary Pneumonia 3 day

Due to: Defilettation

Due to: Carcinoma of sigmoid 1 yr

Other condition: _____
 (Include pregnancy within 3 months of death)

Major findings: _____
 Of operations: H/O
 Of autopsy: _____

Duration

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: 0

23. Signature: T. E. Ruff (M. D. or other) mo
 Address: Jackson mo Date signed: 1-11-44

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

0006

1110

RECEIVED

District Health Officer No. 4
District File Number 244-3376
Date Filed 2-8-44

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..... *B. A. Meyer*

Licensed Embalmer No. 3057

P. O. Address Jackson Me

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.