

FILED JUN 2 1944
Registration District No. 128

Primary Registration District No. 54665

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Rural, N. Campbell Twp.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
At his home P&I
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
In this community 5 yrs. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Greene 37
(c) City or town Rural, N. Campbell Twp.
(If outside city or town limits, write "RURAL")
(d) Street No. P&I (If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Thomas Columbus Blackwell

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Unk. 6. (c) Age of husband or wife if alive Unk. years
7. Birth date of deceased May 5, 1885
(Month) (Day) (Year)

8. AGE: Years 89 Months 1 Days 5 hr. min.

9. Birthplace Unk. Georgia
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

MOTHER FATHER
12. Name Unk. Unk.
13. Birthplace Unk. 9
(City, town, or county) (State or foreign country)
14. Maiden name Unk.
15. Birthplace Unk.
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Irene Snapp
(b) Address P&I Springfield Mo
17. (a) Burial (b) Date thereof June 13-44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Green Lawn

18. (a) Signature of funeral director Fred C. Thomas
(b) Address 1100 Bonville St. Spfld.
19. (a) 6-12-44 (b) (c) (Registrator's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 10
year 1944 hour 5:00 minute P M.

21. I hereby certify that I attended the deceased from 11-16, 1944, to 6-10, 1944
that I last saw h. in alive on 6-10, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Arterio-sclerosis

Due to.....
Due to.....

Other conditions (Include pregnancy within 3 months of death) 97

Major findings: Of operations.....
Of autopsy.....

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?.....

23. Signature W. Willy MD. (M. D. or other)
Address Springfield Mo Date signed 6-12-44

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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..... *Fred C. Thieme*

Licensed Embalmer No. *2899*

P. O. Address *Springfield, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 128

Primary Registration District No. 5465

Registrar's No. 482

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

1. PLACE OF DEATH:

(a) County Greene

(b) City or town Rural in Campbell map
(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 _____ (Specify whether)

In this community 5 yrs
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Greene

(c) City or town Rural
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Thomas C. Blackwell

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

4. Sex M 5. Color or 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 5
(Month) (Day) (Year)

8. AGE: Years 89 Months 1 Days 1 If less than one day _____ min.

9. Birthplace Georgia
(City, town, or county) (State or foreign country)

10. Usual occupation Same

11. Industry or business _____

MOTHER FATHER { 12. Name Wm

13. Birthplace Wm
(City, town, or county) (State or foreign country)

14. Maiden name Wm

15. Birthplace Wm
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Irene Swain

(b) Address Springfield Mo

17. (a) _____ (Burial, cremation, or removal) (b) Date the body was _____
(Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn

18. (a) Signature of funeral director Fred S. Shaw

(b) Address Springfield Mo

19. (a) _____ (b) S. W. Hardy
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June Day 14 Year 1944 Hour _____ Minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death arteriosclerosis

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____

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. Kelly (M.D. or other) M.D.

Address Springfield Mo Date signed _____

SUPPLEMENTARY

21517