

No. 2  
-12-45  
5-17-39  
1 X47070

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED FEB 28 1947**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH  
2000

State File No. **4545**  
Registrar's No. **125**

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH:  
(a) County Greene  
(b) City or town Springfield  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
City Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 Days  
(Specify whether years, months or days)  
In this community Nearly all his lifetime

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Greene  
Springfield  
(c) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1218 N. Marion  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Clarence David Blank  
3. (b) If veteran, name war No  
3. (c) Social Security No. None

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Feb. day 10  
year 1947 hour 12 Midnight M.

4. Sex Male 5. Color or race White  
6. (a) Single, widowed, married, divorced Single  
6. (b) Name of husband or wife \_\_\_\_\_  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Sept. 30 1874  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Feb 7, 1947, to Feb 10, 1947  
that I last saw him alive on Feb 10, 1947  
and that death occurred on the date and hour stated above.  
Immediate cause of death Memoria Duration \_\_\_\_\_

8. AGE: Years Months Days If less than one day  
73 4 10 hr. min.

Due to Prostatic Hypertrophy  
possibly Ca. Prostate.  
Due to Coronary Sclerosis

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

Other conditions (Include pregnancy within 3 months of death)  
\_\_\_\_\_

10. Usual occupation Laborer

11. Industry or business \_\_\_\_\_

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

MOTHER FATHER {  
12. Name David V. Blank  
13. Birthplace ??? Pa.  
(City, town, or county) (State or foreign country)  
14. Maiden name Mary Ellen Lowery  
15. Birthplace ??? Pa.  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Effie Montfort  
(b) Address 1218 N. Marion.

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? \_\_\_\_\_

17. (a) Burial (b) Date thereof 2-12-1947  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Greenlawn

18. (a) Signature of funeral director W. L. Dunn  
(b) Address Springfield, Mo.

23. Signature Blade Blalock (M. D. or other) \_\_\_\_\_  
Address 219 1/2 E. Walnut St Date signed 2/11/47  
Springfield, Mo.

19. (a) 2-12-47 (b) W. J. Handley M.D.  
(Date received local registrar) (Registrar's signature)

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

2025 11 11 10:11 AM

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 *W. McEwan*

Licensed Embalmer No. 2727

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.**