THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 58-009019

XC- FILED APR 3 1958

REG.# 16146 Registration District No. 43 Primary Registration District No. 3007 Registrar's No. 293

1. PLACE OF DEATH a. COUNTY BUTLER	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY WRIGHT
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) POPLAR BLUFF — Inside Limits Yes [X] No [ ]	c. CITY OR TOWN MOUNTAIN GROVE 1141 — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) VA HOSPITAL — Length of stay in 1b: 1 DAY	d. STREET ADDRESS (If outside, give location) 622 WEST FIFTH STREET — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month Day Year
SAMUEL	LEONARD	BLACKWELL	MARCH 21, 1958

5. SEX	6. COLOR OR RACE	7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
MALE	WHITE		4-3-91	66				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country)	12. CITIZEN OF WHAT COUNTRY?
MEAT CUTTER	UNKNOWN	MANES, MISSOURI	U.S.A.

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE
WILLIAM A. BLACKWELL	ARIBELL HARDIN	LURIA BLACKWELL

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
YES	WWI	UNKNOWN	VA HOSPITAL RECORDS	POPLAR BLUFF, MO.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	MYOCARDIAL INSUFFICIENCY.	6 Months.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	ARTERIOSCLEROTIC HEART DISEASE.	10 Years.
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4200

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X] No

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from March 20, 1958, to March 21, 1958

Death occurred at 8:00 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title)	22b. ADDRESS	22c. DATE SIGNED
Robert S. Cohen ROBERT S. COHEN, M.D., Chief, Med. Svc.	VA HOSPITAL, POPLAR BLUFF, MO.	3/21/58

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county)	(State)
Burial	Mar 23, 58	Manes	Manes	Mo.

24. FUNERAL DIRECTOR	ADDRESS	25. DATE REC'D. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE
		3/24/58	[illegible]

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
APR 1 1958
BUTLER CO. HEALTH CENTER
FILE No.

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 ....., Student Embalmer No. ..... working under my personal supervision.

Student ..... Signed Frank Grable
Signature of Student Embalmer

Licensed Embalmer No. 440
P. O. Address Sutter Grove

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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