

NOV 26 1937

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

33543

1. PLACE OF DEATH

County Marion Registration District No. 577
Township Mason Primary Registration District No. 39 29
City Hannibal (No. Levee Army Hospital) St. _____ Ward _____

File No. _____

Registered No. 286

St. _____ Ward _____

2. FULL NAME

John H. Blake
(a) Residence. No. 1248 Jefferson St. _____ Ward _____
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE Col 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) about - 1880

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
about 50 - - -

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Barbar
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Fayette
(STATE OR COUNTRY) Mo

10. NAME OF FATHER James Blake

11. BIRTHPLACE OF FATHER (CITY OR TOWN) MO
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Mary Blake

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) MO
(STATE OR COUNTRY)

14. INFORMANT Nellie Black
(Address) Sallsbury Mo

15. FILED Oct 29, 30 C. E. Cousins
REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10/5 1930

17. I HEREBY CERTIFY, That I attended deceased from 6:30 P.M.
Aug 28 1930 to Oct 5 1930
that I last saw h. l. alive on Oct 5 1930, and that death occurred, on the date stated above, at 6:30 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Broncho-pneumonia
936 Empyema
107A
107A (duration) yrs. mos. 25 ds.
CONTRIBUTORY Chronic myocarditis
(SECONDARY) (duration) 1 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? X-ray - Thorax test
(Signed) Howard B. Sardner M. D.

105 1930 (Address) Hannibal Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Robinson Cem. DATE OF BURIAL 10/10 1930

20. UNDERTAKER Geo E Roberts ADDRESS Hannibal

EVERY ITEM OF INFORMATION SHOULD BE CAREFULLY SUPPLIED. AGE SHOULD BE STATED EXACTLY. PHYSICIANS SHOULD STATE CAUSE OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT.

THIS IS A PERMANENT RECORD

52.0

54.6