

No. 2  
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17-39  
X23159

FILED MAY 16 1941

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **13560**

Registration District No. **399**

Primary Registration District No. **1002**

Registrar's No. **1541**

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Frank

(c) Name of hospital or institution: 323 Grand  
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution about 20 years  
(If not in hospital or institution, write street number or location)

In this community about 20 years  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Oscar S. Blake

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color of race W

6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife Unknown

6. (c) Age of husband or wife if alive \_\_\_\_\_ years (Day) (Year)

7. Birth date of deceased 6 30 68  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>72</u>	<u>8</u>	<u>14</u>	hr. min.

9. Birthplace Havana D.C.  
(City, town, or county) (State or foreign country)

10. Usual occupation Switchman Retired

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

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Myron Blake

(b) Address Dallas, Texas

17. (a) Burial (b) Date thereof 4 19 41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Joseph's

18. (a) Signature of funeral director Peter B. Lopez

(b) Address H. C. - Mo.

19. (a) Apr 18 1941 (b) M. M. Crown  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson

(c) City or town Kansas City 3  
(If outside city or town limits, write "RURAL")

(d) Street No. 523 Grand 8  
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 14 year 41 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from 2:15 P. to \_\_\_\_\_, 19\_\_\_\_; that I last saw him alive and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Chronic suppurative  
Paronychia  
ulcerans

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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

PHYSICIAN

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy Yes

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)

23. Signature Peter B. Lopez D. or other \_\_\_\_\_

Address H. C. - Mo. Date signed \_\_\_\_\_

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

MOTHER FATHER

**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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**