

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town K.C. mo  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. Lukes Hospital 0  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_ hours \_\_\_\_\_ (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME Katharine Elaine Blake

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

4. Sex Female 5. Color or race w 6. (a) Single divorced, married, single 0

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if  
alive \_\_\_\_\_ years

7. Birth date of deceased Sept 15 1941  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day  
\_\_\_\_\_ hr. 20 min.

9. Birthplace Kansas City Mo 0  
(City, town, or county) (State or foreign country)

10. Usual occupation hom

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

MOTHER FATHER { 12. Name Philip David Blake  
13. Birthplace Kansas City, Mo 0  
(City, town, or county) (State or foreign country)  
14. Maiden name Mary Lucille Kannal  
15. Birthplace Kansas City Kansas 0  
(City, town, or county) (State or foreign country)

16. (a) Informant Philip David Blake  
(b) Address 5801 Woodland

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_

19. (a) 9/24/41 (b) Dr. M. M. Brown  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City 3  
(If outside city or town limits, write "RURAL") 8

(d) Street No. 5801 Woodland 0  
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 15<sup>th</sup>  
year 1941 hour 9<sup>05</sup> minute P M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_

that I last saw her alive on Sept 15, 1941; and that death occurred on the date and hour stated above.

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

Erythra blastosis Foetalis

Due to Unknown

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

Major findings: Of operations \_\_\_\_\_

Of autopsy Erythroblastosis Foetalis

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 Phyllis Kullman (M.D. or other) \_\_\_\_\_  
Address 231 W 47 Date signed 9/18/41

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

48  
3  
8

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**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, above space should be left blank.**