

Registration District No. 317

Primary Registration District No. 6096

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

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town Manchester  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Manchester Nursing Home  
(If not in hospital or institution, write street number and location)  
(d) Length of stay: In hospital or institution One Year  
(Specify whether years, months or days)  
Sullivan 40 Yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Franklin  
(c) City or town Sullivan  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Vivian G. Blake

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

4. Sex Male 5. Color or race W 6. (a) Single, widowed, married, divorced Widowed

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

7. Birth date of deceased Dec. 6, 1871  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
72 8 19 hr. min.

9. Birthplace Rockford W. Va.  
(City, town, or county) (State or foreign country)

10. Usual occupation Dentist

11. Industry or business Thomas Flake

12. Name Rovkford, W. Va.

13. Birthplace Sarah Johnson,  
(City, town, or county) (State or foreign country)

14. Maiden name Culpepper, Va.  
(City, town, or county) (State or foreign country)

15. Birthplace Thomas Blake  
(City, town, or county) (State or foreign country)

16. (a) Informant Weston, W. Va.

(b) Address \_\_\_\_\_

17. (a) Cremation, (b) Date thereof Aug. 27, 1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Valhalla

18. (a) Signature of funeral director [Signature]  
(b) Address Sullivan, Mo.

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 25  
year 1943 hour 3 minute 45 A. M.

21. I hereby certify that I attended the deceased from 3-1-42  
to 8-25, 1943  
that I last saw him alive on 8-24, 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral and artery occlusion, 6 hrs

Due to arteriosclerosis

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

Other conditions (Include pregnancy within 3 months of death) [Signature]

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

Of autopsy \_\_\_\_\_

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?  
(Specify type of place)

While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature [Signature] (M. D. or other) MD  
Address Crestwood, Mo. Date signed 8-26-43

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 Embalmer License No. ....  
working under my personal supervision.

Signed *J. T. Williams*

Licensed Embalmer No. **427**

P. O. Address **Sullivan, 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.**

511 ✓  
P. 10  
2035

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. 317

Primary Registration District No. 6076

Registrar's No. 2035

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town Manchester  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Manchester Nursing Home  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 yr (Specify whether years, months or days)  
In this community Sullivan 40 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Franklin  
(c) City or town Sullivan  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

Vivian G. Blake

3. (b) If veteran, name war no

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

4. Sex m 5. Color or race w  
6. (a) Single, widowed, married, divorced w

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

7. Birth date of deceased Dec 16 1871  
(Month) (Day) (Year)

8. AGE: Years 72 Months 5 Days 10 If less than one day \_\_\_\_\_ min.

9. Birthplace Rockford W. Va.  
(City, town, or county) (State or foreign country)

10. Usual occupation Whit

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

12. Name Thomas Blake

13. Birthplace Rockford W. Va.  
(City, town, or county) (State or foreign country)

14. Maiden name Sarah Johnson

15. Birthplace Culpeper Va.  
(City, town, or county) (State or foreign country)

16. (a) Informant Thomas Blake

(b) Address W. Va.

17. (a) Cremation (b) Date thereof Aug 27 1948  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Valhalla

18. (a) Signature of funeral director W. Williams

(b) Address Sullivan, Mo

19. (a) SEP 11 1948 (b) E. G. McSavian  
(Date received for registration) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug Day 25  
Year 1948 Hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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

Immediate cause of death cerebral and coronary occlusion

Due to arteriosclerosis

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

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

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

Of autopsy 8201

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 C. H. Denny M.D. (M. D. or other) \_\_\_\_\_  
Address Creed Cedar Date signed 8/26/48

Duration 1 week  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

(a) (b)

29257