

FILED JUL 26 1944 318

1003

6277

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

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

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

1. PLACE OF DEATH:

(a) County ST LOUIS MO  
(b) City or town ST LOUIS MO  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: HOMER G. PHILLIPS HOSPITAL.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 DAY  
20, YEARS. (Specify whether years, months or days)

3. (a) PRINT FULL NAME MR LEROY BLALOCK.

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

4. Sex MALE. 5. Color or race COL. 6. (a) Single, widowed, married, divorced WIDOW  
6. (b) Name of husband or wife MAGGIE BLALOCK. 6. (c) Age of husband or wife if alive 43 years  
7. Birth date of deceased April 25 1890  
(Month) (Day) (Year)

8. AGE: Years 54 Months 2 Days 11 If less than one day hr. min.

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

10. Usual occupation LABOR.

11. Industry or business

MOTHER FATHER  
12. Name Unknown  
13. Birthplace Unknown (City, town, or county) (State or foreign country) 9  
14. Maiden name Unknown  
15. Birthplace Unknown (City, town, or county) (State or foreign country) 9

16. (a) Informant MAGGIE BLALOCK.  
(b) Address 18 33, O-FALLON ST.

17. (a) BURIAL, (b) Date thereof JULY 15, 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation WASHINGTON PARK CEMETERY

18. (a) Signature of funeral director: M. VASSER; L. THOMAS

(b) Address 2812 Cass

19. (a) JUL 15 1944 (Date received local registrar)  
[Signature] (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County 000  
(c) City or town ST. LOUIS (If outside city or town limits, write "RURAL") 921  
(d) Street No. 28 04, DICKSON, (If rural, give location)  
(e) Citizen of foreign country? CITIZEN, (Yes or No)  
If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 6  
year 1944 hour 3-35 minute P.M.

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

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

Ruptured Aneurysm  
(Aortic Arch)

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

Due to Syphilitic

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

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

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

PHYSICIAN

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) (e) Means of injury 3

Signature: [Signature] (M. D. or other)

Address [Address] Date signed 7-15-44

**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.....

*Chas. L. Howell*

Licensed Embalmer No. *2452*

P. O. Address *2834 Gamble*

**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.**