

FILED AUG 10 1944

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 2052

Registration District No. 1

Primary Registration District No. 3000

Registrar's No. 170

1. PLACE OF DEATH:

(a) County Adair

(b) City or town Kirksville  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
Grim-Smith Hospital  
(If not in hospital or institution, write street number or location) 0

(d) Length of stay: In hospital or institution 25 years. (Specify whether years, months or days)

In this community 25 years.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Adair

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

(d) Street No. 216 E. Harrison  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country 0

3. (a) PRINT FULL NAME William Phillip Blake

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

3. (c) Social Security No. None

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Carrie Thane Blake

6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased Sept. 23 1858  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>85</u>	<u>8</u>	<u>6</u>	hr. _____ min.

9. Birthplace Muscatine Iowa  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Groceryman

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

12. Name Jacob Blake

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

14. Maiden name Emily Bershine

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

16. (a) Informant Mrs. Carrie Blake

(b) Address Kirksville, Mo.

17. (a) Burial (b) Date thereof 7/3/44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Highland Park

18. (a) Signature of funeral director [Signature]

(b) Address Kirksville, Mo.

19. (a) 7/19/44 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 29  
year 1944 hour 11:30 minute \_\_\_\_\_ P: M.

21. I hereby certify that I attended the deceased from June 23  
1944 to June 29 1944

that I last saw him alive on June 29 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Uremia, convulsion Duration few minutes

Due to Prostatic obstruction

Due to Prostatic obstruction for 1 yr

(complete retention) for 10 days (relieved by catheter) 2 yrs

Other conditions Cardiovascular, renal disease 20 years

(Include pregnancy within 3 months of death)

Major findings:  
Of operations 1310

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? \_\_\_\_\_

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

23. Signature George E. Gans (M. D. or other) MD

Address Kirksville, Missouri Date signed 7/16/44

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

MOTHER FATHER

RECEIVED

District Health Officer No. 10

District File Number 8-44-1327

Date Filed AUG 9 1944

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 D. E. Riley

Licensed Embalmer No. 4181

P. O. Address Kestville 40

**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.**