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THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **28699**

FILED AUG 28 1944

Registration District No. **177**

Primary Registration District No. **2002**

Registrar's No. **1763**

1. PLACE OF DEATH:

(a) County **St. Louis**

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

(c) Name of hospital or institution:
Christian Old Peoples Home
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community _____
years, months or days

3. (a) PRINT FULL NAME **W. Barnett Blakemore**

3. (b) If veteran, name war **None**

3. (c) Social Security No. **None**

4. Sex **Male** 5. Color or race **White**

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

6. (b) Name of husband or wife **Nell Porter Blakemore**

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

7. Birth date of deceased **September 23, 1876**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

67 **10** **38** hr. min.

9. Birthplace **Paris Tennessee**
(City, town, or county) (State or foreign country)

10. Usual occupation **Minister**

11. Industry or business _____

MOTHER FATHER { 12. Name **Robert M. Blakemore**

13. Birthplace **Tennessee**
(City, town, or county) (State or foreign country)

14. Maiden name **Elizabeth Walker**

15. Birthplace **Tennessee**
(City, town, or county) (State or foreign country)

16. (a) Informant **W. B. Blakemore Jr.**

(b) Address **Chicago Illinois**

17. (a) **Burial** (b) Date thereof **Aug 23, 1944**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Paris, Tennessee**

18. (a) Signature of funeral director **Shepard Funeral Home**

(b) **1167 Hamilton Avenue.**

19. (a) **AUG 23 1944** (b) **C. L. McFarlan**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis**

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

(d) Street No. **6600 Washington Avenue**
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **30**, 1944
year _____ hour **9:30** minute **A** M.

21. I hereby certify that I attended the deceased from **Aug 5, 44**
_____ 19 _____ 19 _____
that I last saw him alive on **Aug 20** 19 **44**
and that death occurred on the date and hour stated above.

Immediate cause of death **Apoplexy** Duration **2 weeks**

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: **8301**

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)

23. Signature **C. E. Gilchrist** (M.D. or other) **MD**
Address **101 Theatre Bldg** Date signed **8/21/44**

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

Handwritten:
TAN
L. J. Holland
to
the
body

Handwritten:
J. J. J. J. J.

AUG 31 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 *G. W. Wilkinson*
Licensed Embalmer No. *3575*

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.