S. No. 2
M—5-43
5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 6 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 41343

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 331

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution: 735 N. Osage st. (If not in hospital or institution, write street number or location)

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

In this community 47 years (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 49

(c) City or town Independence (If outside city or town limits, write "RURAL") 4

(d) Street No. 735 No Osage St. (If rural, give location) 4

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

If yes, name country —

3. (a) PRINT FULL NAME Shaffer Orel Blake

3. (b) If veteran, name war —

3. (c) Social Security No. 486-43-7241

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Ruth Blake

6. (c) Age of husband or wife if alive 47 years

7. Birth date of deceased Jan (Month) 4 (Day) 1887 (Year)

8. AGE: Years 57 Months 11 Days 10 If less than one day ___ hr. ___ min.

9. Birthplace Oak Hill (City, town, or county) Ohio (State or foreign country)

10. Usual occupation Car Inspector

11. Industry or business Union Tank Coal Co Sugar Creek

FATHER
12. Name James L Blake
13. Birthplace Shelby County (City, town, or county) Iowa (State or foreign country)

MOTHER
14. Maiden name Emma E. Faulkner
15. Birthplace Oak Hill (City, town, or county) Ohio (State or foreign country)

16. (a) Informant Mrs Ruth Blake

(b) Address 735 N. Osage St Ind Mo

17. (a) Dec 16 1944 (Burial, ~~cremation, removal~~) (b) Date thereof Dec 16-44 (Month) (Day) (Year)

(c) Place: burial or ~~cremation~~ Woodlawn

18. (a) Signature of funeral director Ott + Mitchell

(b) Address 310 N. Main St, Indep Mo

19. (a) 12-15-1[illegible]44 (Date received [illegible]gistrar) (b) James W. Ross (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 14 year 1944 hour 3 minute 45 A.M.

21. I hereby certify that I attended the deceased from Dec 11, 1944, to Dec 14, 1944 that I last saw him alive on Dec 13, 1944; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Broncho pneumonia	4 days
Due to Influenza	7 days
Due to	
Other conditions Asthma (Include pregnancy within 3 months of death)	chronic

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? (Specify type of place)

While at work? (e) Means of injury —

23. Signature J. C. Hickinson (M. D. ~~or other~~)

Address Independence Date signed Dec 15

1163

(Licensed Embalmer's Statement on Reverse Side)

MAR 3 1949

JAN 10 1945

AUG 4 1950

AUG

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 me

, Registered Apprentice No.

working under my personal supervision.

Signed Henry L. Mitchell

Licensed Embalmer No. 3925

P. O. Address Lindley 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.