

No. 2
M-5-43
5-17-39
X36671

FILED NOV 19 1945
STANDARD CERTIFICATE OF DEATH
1003

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____
 (b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Louis City Hospital 0
(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 **Michael P. Blake**

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

4. Sex **Male 0** **5. Color or race** **White 0** **6. (a) Single, widowed, married, divorced** **Single**

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

7. Birth date of deceased **About 1872**
(Month) (Day) (Year)

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

About 73 hr. _____ min.

9. Birthplace **Ballingary County Ireland 4**
(City, town, or county) (State or foreign country)

10. Usual occupation **Unemployed**

11. Industry or business _____

MOTHER FATHER { **12. Name** **James Blake**

{ **13. Birthplace** **Ireland 4**
(City, town, or county) (State or foreign country)

{ **14. Maiden name** **Mary Agnes Burns**

{ **15. Birthplace** **Ireland 4**
(City, town, or county) (State or foreign country)

16. (a) Informant **Betty Hayman**

(b) Address **1116 E. 10th St., Davenport, Ia.**

17. (a) Burial **(b) Date thereof** **11-3-45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cemetery**

18. (a) Signature of funeral director **Albert H. Hoppe**

(b) Address **4700 Washington Blvd.**

19. (a) NOV 2 1945 **(b)** _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County _____

(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")

(d) Street No. **218 S. 4th St.**
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct.** day **31**
 year **1945** hour **2** minute **15 0** 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 _____
Chrom Myocarditis
 Due to _____
 Due to _____

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

Major findings:
 Of operations _____

Of autopsy _____

Duration _____

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) (c) Means of injury **3**

23. Signature **Patrick E. Taylor** (M.D. or other) _____
Deputy Coroner Date signed **11-2-45**

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

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.

*Embalmed
separately*

Signed.....

Licensed Embalmer No.....

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 318Primary Registration District No. 1003Registrar's No. 9509

1. PLACE OF DEATH:

(a) County St. Louis Mo.
 (b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: St. Louis City Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 15 days
(Specify whether
 In this community years
years, months or days)

3. (a) PRINT FULL NAME

Michael J. Blake

3. (b) If veteran, name was Spanish-Am. 3. (c) Social Security No. 102-18-586

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

6. (b) Name of husband or wife None 6. (c) Age of husband or wife if alive None years

7. Birth date of deceased (Month) 11 (Day) 26 (Year) 45

8. AGE: Years 45 Months 0 Days 0 If less than one day hr. 0 min. 0

9. Birthplace Bellingary County, Limerick, Ireland
(City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business None

12. Name Bellingary County, Limerick, Ireland

13. Birthplace Bellingary County, Limerick, Ireland
(City, town, or county) (State or foreign country)

14. Maiden name None

15. Birthplace Bellingary County, Limerick, Ireland
(City, town, or county) (State or foreign country)

16. (a) Informant None

(b) Address None

17. (a) None (b) Date thereof (Month) 11 (Day) 26 (Year) 45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation None

18. (a) Signature of funeral director None

(b) Address None

19. (a) 11-26-45 (b) J. Bredack
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis
 (c) City or town St. Louis
(If outside city or town limits, write "RURAL")
 (d) Street No. None
(If rural, give location)
 (e) Citizen of foreign country? None (Yes or No)
 If yes, name country None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 Day 26 Year 1945 Hour 10 minute 30 M.

21. I hereby certify that I attended the deceased from 11/26/45 to 11/26/45 and that death occurred on the date and hour stated above. Immediate cause of death None

Duration

Due to None

Due to None

Other conditions None
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: None
 Of operations None

Of autopsy None

If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) None

(b) Date of occurrence None

(c) Where did injury occur? (City or town) None (County) None (State) None

(d) Did injury occur in or about home, on farm, in industrial place, in public place? None

While at work? None (Specify type of place) (e) Means of injury None

23. Signature None (M. D. or other) None

Address None Date signed None

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

MOTHER FATHER

SUPPLEMENTARY

Underline the cause to which death should be charged statistically.

35056