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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 14 1947

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

10560

State File No.

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2672

1. PLACE OF DEATH:

(a) County

(b) City or town ~~City Infirmary~~ St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: City Infirmary
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 yr. 6 mo. 20 das (Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

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

(d) Street No. 5600 Arsenal St.
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME TOM BLAKELY, JR.

3. (b) If veteran, name war ---

3. (c) Social Security No. --

4. Sex male 2

5. Color or race Colored

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

6. (b) Name of husband or wife Emma Tyle

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

7. Birth date of deceased July (Month) 7 (Day) 1860 (Year)

8. AGE: Years 86 Months 8 Days 27 If less than one day hr. min.

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

10. Usual occupation none

11. Industry or business

FATHER
12. Name Donald Blakely
13. Birthplace Mississippi (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Sarah Ann Foster
15. Birthplace Mississippi (City, town, or county) (State or foreign country)

16. (a) Informant City Infirmary
(b) Address 5600 Arsenal St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-9-47 (Month) (Day) (Year)
(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director Chas. J. Gates
(b) Address 4107 Finney Ave.

19. (a) APR 7 1947 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 4 year 1947 hour 9 minute 30 A.M.

21. I hereby certify that I attended the deceased from July 1, 1945 April 4, 1947, 19 to , 19 ; that I last saw h alive on April 4, 1947, 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cardio-Cerebro-Nephritis	
Due to Syndrome	2½ years
Due to	
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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature Palmer Lawrence Bordish (M. D. or other)
Address City Infirmary Date signed 4/4/47

(Licensed Embalmer's Statement on Reverse Side)

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 John Cunningham, Registered Apprentice No. ....., working under my personal supervision.

Signed .....

Licensed Embalmer No. 1825

P. O. Address 4107 Finney Ave.

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.