

No. 2
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17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **36382**

FILED DEC 4 1948
Registration District No. **149**

Primary Registration District No. **1002**

Registrar's No. **4587**

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

1. PLACE OF DEATH:

(a) County **JACKSON**
(b) City or town **KANSAS CITY**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
7939 GARFIELD AVENUE 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **4 YEARS** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **MRS. MARY ALICE BLAKE**

3. (b) If veteran, name war **NO** 3. (c) Social Security No. **NONE**

4. Sex **FEMALE** 5. Color or race **WHITE**
6. (a) Single, widowed, married, divorced **MARRIED**
6. (b) Name of husband or wife **REV. PEARL FORREST BLAKE**
6. (c) Age of husband or wife if alive **77** years
7. Birth date of deceased **JANUARY 21 1872**
(Month) (Day) (Year)

8. AGE: Years **76** Months **9** Days **16** If less than one day hr. min.

9. Birthplace **ELKVILLE ILLINOIS**
(City, town, or county) (State or foreign country)

10. Usual occupation **HOUSE WIFE**

11. Industry or business **AT HOME**

MOTHER FATHER
12. Name **EDMUND ROOT**
13. Birthplace **VIRGINIA**
(City, town, or county) (State or foreign country)
14. Maiden name **MARY ANN RHOADES**
15. Birthplace **VIRGINIA**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Pearl Forest Blake**

(b) Address **7939 Garfield Avenue**

17. (a) **REMOVAL** (b) Date thereof **NOV. 10, 1948**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **OSCEOLA, MISSOURI**

18. (a) Signature of funeral director **P. W. Newcomer's Sons**

(b) Address **1401 Brush Creek Blvd**

19. (a) **11-10-48** (b) **Stralaine Holmes**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **JACKSON 48**
(c) City or town **KANSAS CITY 3**
(If outside city or town limits, write "RURAL")
(d) Street No. **7939 GARFIELD AVENUE 8**
(If rural, give location)
(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country **---**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **NOVEMBER** day **7TH**
year **1948** hour **4** minute **20 P.M.**

21. I hereby certify that I attended the deceased from **NOV. 4**, 19**48**, to **NOV. 7**, 19**48**;
that I last saw **HER** alive on **NOV. 7**, 19**48**;
and that death occurred on the date and hour stated above.

Immediate cause of death **CARDIAC DECOMPENSATION** Duration **3 days**

Due to **CORONARY OCCLUSION**

Other conditions (Include pregnancy within 3 months of death) **95C**

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? **---**

George K. Landis (Specify type of place) While at work? (Specify type of place) Means of injury **---**
23. Signature **George K. Landis** (M. D. or other) **MD.**
Address **1630 Professional Bldg** Date signed **11/12/48**

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1:00.3.003m.

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 Robert Ray

Licensed Embalmer No. 4182

P. O. Address Kansas City, 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.