

FILED OCT 13 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **31608**
8583

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| BIRTH NO. _____ | | REG. DIST. NO. 318 | | PRIMARY REG. DIST. NO. 1003 | | Registrar's No. _____ | |
| 1. PLACE OF DEATH a. COUNTY _____ | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY _____ | | | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis | | c. LENGTH OF STAY (In this place) _____ | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis | | d. STREET ADDRESS (If rural, give location) 15- 4015 Eichelberger Ave. | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Park Lane Hospital | | | | d. STREET ADDRESS (If rural, give location) 15- 4015 Eichelberger Ave. | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) William b. (Middle) L. c. (Last) Blackard | | | 4. DATE OF DEATH (Month) (Day) (Year) 10-3-1949 | | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married | | 8. DATE OF BIRTH April 11 1880 | |
| 9. AGE (In years last birthday) 69 | | 10. MONTHS 10 | | 11. DAYS 3 | | 12. HOURS 10 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocery Clerk | | 10b. KIND OF BUSINESS OR INDUSTRY Grocery | | 11. BIRTHPLACE (State or foreign country) Illinois | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13a. FATHER'S NAME John Blackard | | | 13b. MOTHER'S MAIDEN NAME Unknown | | | 14. NAME OF HUSBAND OR WIFE Stella Blackard | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 489-14-3960 | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Stella Blackard 4015 Eichelberger Ave | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death. | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma urinary tract | | | | | | | |
| ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Carcinoma bladder | | | | | | | |
| DUE TO (c) _____ | | | | | | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. _____ | | | | | | | |
| 19a. DATE OF OPERATION 3-10-49 | | 19b. MAJOR FINDINGS OF OPERATION Cystoscopic (Ca Bladder) | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____ | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) 520 | | 21d. (STATE) 181X | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____ | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? 181X | | | |
| 22. I hereby certify that I attended the deceased from 3-7, 1949 , to 10-3, 1949 , that I last saw the deceased alive on 10-3, 1949 , and that death occurred at 1:20 Pm. , from the causes and on the date stated above. | | | | | | | |
| 23a. SIGNATURE P.B. Cappel | | | | 23b. ADDRESS 3284 Ivanhoe Ave | | 23c. DATE SIGNED 10-5-49 | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 24b. DATE 10-6-1949 | | 24c. NAME OF CEMETERY OR CREMATORY Omaha Cemetery | | 24d. LOCATION (City, town, or county) (State) Omaha Illinois Ill. | |
| DATE REC'D BY LOCAL REG. OCT 5 1949 | | REGISTRAR'S SIGNATURE J. B. Sauter | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Ziegenfuss Bros 6409 Gravois Ave | | | |

Dr. P. B. Cappel 3284 Ivanhoe Ave
HI 2502
WRITE PLAINLY—USING 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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Henry M. Brammer

Licensed Embalmer No. 4200

P. O. Address St. Louis

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.