S. No. 300
v. 10-48

FILED APR 10 1950

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 10175

BIRTH NO. #109771 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 3091

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

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St.Louis, Missouri
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St.Louis City Hospital #1.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St.Louis
d. STREET ADDRESS (If rural, give location) 17 — 3946a Cleveland Ave.

3. NAME OF DECEASED (Type or Print)
a. (First) ROBERT
b. (Middle)
c. (Last) BLAIR

4. DATE OF DEATH (Month) (Day) (Year) March 31st, 1950

5. SEX male 0
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widower
8. DATE OF BIRTH Jan.26,1872
9. AGE (In years last birthday) 78 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman retired
10b. KIND OF BUSINESS OR INDUSTRY Marx & Haas
11. BIRTHPLACE (State or foreign country) Missouri 0
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME James Blair
13b. MOTHER'S MAIDEN NAME Cecelia Smith
14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 488-10-1294
17. INFORMANT'S SIGNATURE OR NAME Eula Smith 3531 Texas — ADDRESS

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Anemia — INTERVAL BETWEEN ONSET AND DEATH ?

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b) Benign Prostatic Hypertrophy ?

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
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

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) 610 X (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3/25/50, 19__, *to* 3/31/50, 19__, *that I last saw the deceased alive on* 3/31/50, 19__, *and that death occurred at* 11:50am *m., from the causes and on the date stated above.*

23a. SIGNATURE Allen P. Klippel M.D. (Degree or title)
23b. ADDRESS 1515 Lafayette Ave.,
23c. DATE SIGNED 3/31/50

24a. BURIAL, CREMATION, REMOVAL (Specify) burial
24b. DATE 4-3-50
24c. NAME OF CEMETERY OR CREMATORY Sunset Burial Park
24d. LOCATION (City, town, or county) St.Louis Co., Mo. (State)

DATE REC'D BY LOCAL REG. APR 3
REGISTRAR'S SIGNATURE J. B. Lasater
25. FUNERAL DIRECTOR'S SIGNATURE Zugenheim Bros 6409 Gravois AVE — ADDRESS

(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 .....

....., 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.