FILED JUL 29 1957

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 24129

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 735

1. PLACE OF DEATH
a. COUNTY Greene
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield — Inside Limits Yes [X] No [ ]
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1119 Nichols — Length of stay in 1b: 10 yrs.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Greene
c. CITY OR TOWN Springfield, — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) 1119 Nichols — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First: JOHN Middle: Last: BLAKE, SR.

4. DATE OF DEATH Month Day Year: July 19, 1957

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [X]
8. DATE OF BIRTH: Sept. 21, 1863
9. AGE (In years on last birthday): 93 — 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): Interior Decorator
10b. KIND OF BUSINESS OR INDUSTRY: Interior Decorator
11. BIRTHPLACE (City and state or country): Arkansas
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME: Unknown
13b. MOTHER'S MAIDEN NAME: Unknown
14. NAME OF HUSBAND OR WIFE: divorced

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.: none
17. INFORMANT: LeRoy Blake Address: Springfield, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Probably Coronary Occlusion
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
UNATTENDED BY A PHYSICIAN
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Cardiac Insufficiency 4201
INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from July 19, 1957 to July 19, 1957 that I last saw him alive on July 19, 1957. Death occurred at 4:00 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE James R. Wood (Degree or title) M.D.
22b. ADDRESS Health Officer Greene County Health Dept.
22c. DATE SIGNED 7/23/57

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: July 23, 1957
23c. NAME OF CEMETERY OR CREMATORY: Hazelwood
23d. LOCATION (City, town, or county) (State): Springfield Mo.

24. FUNERAL DIRECTOR: Ralph Thieme ADDRESS: Springfield, Mo.
25. DATE RECD. BY LOCAL REG.: 7-23-57
26. REGISTRAR'S SIGNATURE: Edith Williamson

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 ..... Signed Joe Mason

Signature of Student Embalmer

Licensed Embalmer No. 4568

P. O. Address Springfield, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.