Health, Welfare Public Service

300 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED OCT 21 1957

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 37175

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9274

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis — Inside Limits Yes ☐ No ☐	c. CITY OR TOWN St. Louis — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Bethesda Gen. Hospital — Length of stay in Hospital 2	d. STREET ADDRESS (If outside, give location) 4936 Nagel — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print)	First: Jennie	Middle:	Last: Blake	4. DATE OF DEATH: Month Oct, Day 3, Year 1957
5. SEX: female	6. COLOR OR RACE: white	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH: unk 1868	9. AGE (In years last birthday): 89 — 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): at home	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country): Minnesota		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: not known		14. MOTHER'S MAIDEN NAME: not known		
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: Gregory L Flatt	Address: 9915 Norcross Dr.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebral Thrombosis Rt. — 8 days

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) Arteriosclerotic vascular disease — chr.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 332X

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

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 Sept 23 1957 to Oct. 3rd 1957 and last saw her/him alive on 10/2/57 — Death occurred at 1:15 a m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): O D Leabaugh MD	22b. ADDRESS: Webster Groves Mo	22c. DATE SIGNED: 10/4/57

23a. BURIAL, CREMATION, REMOVAL (Specify): burial	23b. DATE: 10/5/1957	23c. NAME OF CEMETERY OR CREMATORY: Bellefontaine Cemetery	23d. LOCATION (City, town, or county) (State): St. Louis, Mo.
24. FUNERAL DIRECTOR: J L Ziegenhein & Sons	ADDRESS: 7027 Gravois	25. DATE RECD. BY LOCAL REG.: OCT 5 57	26. REGISTRAR'S SIGNATURE: J Earl Smith MD acm

(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 emb

by me, or by ....., Student Embalmer No.....

working under my personal supervision.

Student.....
Signature of Student Embalmer

Signed Donald E Binz

Licensed Embalmer No. 486

P. O. Address 7027 Gra

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F
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.