

FILED DEC 10 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

41678  
STATE FILE NUMBER

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

11419

|  |                                  |   |  |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY                                 |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR <b>St. Louis</b><br>TOWN   |                                  | c. CITY OR TOWN <b>St. Louis</b>  |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>St. Louis City Hospital #1</b>   |                                  | d. STREET ADDRESS (If outside, give location)<br><b>1518 Warren St.</b>   |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>Blakeney</b>   |                                  | 4. DATE OF DEATH<br>Month <b>11</b> Day <b>27</b> Year <b>57</b>  |  |
| 5. SEX<br><b>MALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>11 Aug 1892</b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>on SOC SEC</b>   |                                  | 11. BIRTHPLACE (City and state or country)<br><b>St. Louis, Mo.</b>   |  |
| 13a. FATHER'S NAME<br><b>ARTHUR WELLINGTON Adams</b>   |                                  | 14. NAME OF HUSBAND OR WIFE<br><b>Mollie</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>  |                                  | 17. INFORMANT<br><b>Mollie Adams</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b><br>DUE TO (b) <b>undetermined</b><br>DUE TO (c) <b>Organism</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>CARCINOMATOSIS</b> |                                  | 19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)  |  |
| 20c. TIME OF INJURY<br>Hour <b>1:10a</b> Month <b>11</b> Day <b>27</b> Year <b>57</b>  |                                  | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |                                  | 20f. CITY, TOWN, OR LOCATION<br><b>St. Louis</b>  |  |
| 21. I attended the deceased from <b>11-18-57</b> to <b>11-27-57</b> and last saw him alive on <b>11-27-57</b><br>Death occurred at <b>1:10a</b> on the date stated above; and to the best of my knowledge, from the causes stated.   |                                  | 22a. SIGNATURE (Name or title)<br><b>Robert F. Owens</b>  |  |
| 22b. ADDRESS<br><b>1515 Lafayette</b>  |                                  | 22c. DATE SIGNED<br><b>11-27-57</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>removal</b>  |                                  | 23b. DATE<br><b>11-30-57</b>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Memorial Park Cemetery</b>  |                                  | 23d. LOCATION (City, town, or county)<br><b>St. Louis Co., Mo.</b>  |  |
| 24. FUNERAL DIRECTOR<br><b>Leidner Und. Co.</b>  |                                  | 25. DATE RECD. BY LOCAL REG.<br><b>NOV 29 '57</b>   |  |
| 26. REGISTRAR'S SIGNATURE<br><b>Carl Smith</b>   |                                  |   |  |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

Securing the medical certification in this specific manner required by 1957-140 MO RS 1949.

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 .....  
Signature of Student Embalmer

Signed Al Mayfield .....

Licensed Embalmer No. 3077

P. O. Address St. Louis 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.