

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-006907

STATE FILE NUMBER

21261

FILED FEB 17 1959

Registration District No. Primary Registration District No.

Registrar No.

300  
-57  
5  
19  
4  
0

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 <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Johns Hosp.		Length of stay in lb 1 week	d. STREET ADDRESS (If outside, give location) 5478a Thrush Ave. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last ISABELLE G. BLASE			4. DATE OF DEATH Month Day Year Feb. 3 1959		
---	--	--	---	--	--

5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 18, 1908	9. AGE (In years last birthday) 50	10. FUNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
------------------	---------------------------	---	-----------------------------------	---------------------------------------	---	----------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework	10b. KIND OF BUSINESS OR INDUSTRY home	11. BIRTHPLACE (City and state or country) St. Louis Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
--	---	---	--

13a. FATHER'S NAME Adolph Wilke	13b. MOTHER'S MAIDEN NAME Josephine DeCharles	14. NAME OF HUSBAND OR WIFE Wm. E. Blase
------------------------------------	--	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 498 01 6421	17. INFORMANT Robert Blase	Address 5478a Thrush Ave.
---	--	-------------------------------	------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute myocardial infarction</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <i>Thrombosis and occlusion of Coronary artery</i>	<i>4 hrs</i>
	DUE TO (c) <i>Hypertension</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Hypertension 465X</i>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT SUICIDE HOME <input type="checkbox"/> <input type="checkbox"/> <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 Hour Month, Day, Year a.m. p.m.	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 COUNTY STATE
---	--	--	---

21. I attended the deceased from Death occurred at <i>1/28/59</i> to <i>2/3/59</i> and last saw her alive on <i>2/3/59</i> <i>10:30 A.M.</i> m on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE (Degree or title) <i>D. Pranger M.D.</i>	22b. ADDRESS <i>4957 Maryland</i>	22c. DATE SIGNED <i>2/5/59</i>
--	--------------------------------------	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE 2/6/59	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis County Mo.
--	---------------------	--	---

24. FUNERAL DIRECTOR Buchholz Mortuary 5967 W. Florissant	ADDRESS	25. DATE RECD. BY LOCAL REG. FEB 5 '59	26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>
--	---------	---	--

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

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 .....  
Signature of Student Embalmer

Signed *Walter M. Berchelt* .....

Licensed Embalmer No. *4551* .....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.