

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-019959

STATE FILE NUMBER

FILED MAY 18 1959

Registration District No.

317

Primary Registration District No.

500

Registrar's No.

1274

300
-57
1
9
8

1. PLACE OF DEATH a. COUNTY <i>St. Louis</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>St. Louis</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Koch</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Robert Koch Hospital</i>		Length of stay in 1b <i>1016 days.</i>	d. STREET ADDRESS (If outside, give location) <i>2213 Chouteau</i>
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <i>Eugene</i> Middle <i>Blakely</i> Last <i>Blakely</i>			4. DATE OF DEATH Month <i>5</i> Day <i>6</i> Year <i>1959</i>		
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5. SEX <i>male</i>	6. COLOR OF RACE <i>colored</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7/23/1884</i>	9. AGE (In years at birth) <i>74</i>	IF UNDER 1 YEAR Months <i>1</i> Days <i>14</i>	IF UNDER 24 HRS. Hours <i>1</i> Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>nil</i>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <i>Mississippi</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
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13a. FATHER'S NAME <i>? Blakely</i>	13b. MOTHER'S MAIDEN NAME <i>Hanna Wheeler</i>	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>	16. SOCIAL SECURITY NO.	17. INFORMANT Address <i>Records of Koch Hospital.</i>
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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>Chronic pulmonary tuberculosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Four years?</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		
DUE TO (b) _____		
DUE TO (c) _____		<i>002x</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

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.)
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20c. TIME OF INJURY Hour _____ 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
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21. I attended the deceased from <i>7/24/56</i> to <i>5/6/1959</i> and last saw him alive on <i>5/5/1959</i> Death occurred at <i>5/6/1959 12.15 a.m.</i> on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>Bernard Swerman, M.D.</i>	22b. ADDRESS <i>Robert Koch Hospital, Koch No.</i>	22c. DATE SIGNED <i>5/6/59</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE <i>5-11-59</i>	23c. NAME OF CEMETERY OR CREMATORY <i>FATHER DICKSON</i>	23d. LOCATION (City, town, or county) (State) <i>ST. LOUIS COUNTY, MO.</i>
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24. FUNERAL DIRECTOR ADDRESS <i>MRS. S.J. WATSON 2769 Chouteau</i>	25. DATE RECD. BY LOCAL REG. <i>5-7-59</i>	26. REGISTRAR'S SIGNATURE <i>John L. Murphy, M.D.</i>
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(Licensed Embalmer's Statement on Reverse Side)

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 *Fulton E. Cull*

Licensed Embalmer No. *4198*
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.