

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-030253

FILED VS SEP 11 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 7965** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Saint Louis		c. CITY OR TOWN Saint Louis	
Length of stay in 1b		(Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Enr. Homer G. Phillips		d. STREET ADDRESS (If outside, give location) 4009 A. Cote-Brillante	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Douglas Middle D. Last Blake			4. DATE OF DEATH Month 8 Day 23 Year 1959		
--	--	--	---	--	--

5. SEX Male	6. COLOR OR RACE Colored	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6/15/1915	9. AGE (last birthday) 44	IF UNDER 1 YEAR Months 2 Days 8	IF UNDER 24 HR Hours _____ Min. _____
-----------------------	------------------------------------	---	--------------------------------------	-------------------------------------	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and state or country) Arkansas	12. CITIZEN OF WHAT COUNTRY U.S.A.
---	--	---	--

13a. FATHER'S NAME Luther Blake	13b. MOTHER'S MAIDEN NAME Lucille Wright	14. NAME OF HUSBAND OR WIFE Hattie Mae Blake
---	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW2	16. SOCIAL SECURITY NO. ?	17. INFORMANT Hattie Mae Blake	Address 4009 A. Cote-Brillante
--	-------------------------------------	--	--

18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Atherosclerosis		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
---	--	--

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)
---	---	--

20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year
---	------------------

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 _____ to _____ and last saw her/him alive on _____.
Death occurred at _____ **1130 A** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Patrick C. Taylor (Degree or title)	22b. ADDRESS 1500 Clark	22c. DATE SIGNED 8.27.59
--	-----------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 8-31-59	23c. NAME OF CEMETERY OR CREMATORY National Cemetery	23d. LOCATION (City, town, or county) Jefferson Barracks, Missouri
---	-----------------------------	--	--

24. FUNERAL DIRECTOR Ellis Funeral Home, 2820 Stoddard Street	ADDRESS	25. DATE RECD. BY LOCAL REG. AUG 27 '59	26. REGISTRAR'S SIGNATURE Lead Smith, M.D.
---	---------	---	--

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Gulston C. Culka

Licensed Embalmer No: 4190

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.