

FEDERAL BUREAU OF INVESTIGATION - DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 4 6-2 2 0

FILED VS DEC 21 1959

Registration District No. 317 Primary Registration District No. 544 Registrar's No. 3033 STATE FILE NUMBER

UNRECORDED

| | | | | | | | |
|--|--|---|--|---|--|---|----------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>St. Louis</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Jefferson</u> | | | |
| b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kirkwood</u> | | Length of stay in 1b | | c. CITY OR TOWN <u>Fenton</u> | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St Joseph's Hosp DOA</u> | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (if outside, give location) <u>Saline Rd.</u> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Milton</u> Middle <u>W</u> Last <u>Blair</u> | | | | 4. DATE OF DEATH Month <u>November</u> Day <u>15</u> Year <u>1959</u> | | | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH <u>12/2/1916</u> | 9. AGE (last birthday) <u>42</u> | IF UNDER 1 YEAR Months | IF UNDER 24 HR Days |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>produce</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>A & P Super Market</u> | | 11. BIRTHPLACE (City and state or country) <u>Kansas City, Mo.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | |
| 13a. FATHER'S NAME <u>Will Blair</u> | | | 13b. MOTHER'S MAIDEN NAME <u>Josephine Johnson</u> | | 14. NAME OF HUSBAND OR WIFE <u>Lillian</u> | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes WW-II</u> | | 16. SOCIAL SECURITY NO. <u>WW-11</u> | | 17. INFORMANT Address <u>Lillian Blair Rout 2 Fenton, Mo.</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carbon monoxide poisoning</u> | | | | | | | 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) _____ | | | | | | | |
| 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 type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT <input checked="" 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.) <u>Accidental inhalation of carbon monoxide poisoning</u> | | | |
| 20c. TIME OF INJURY <u>7:00 a.m.</u> | Month, Day, Year <u>11/15/59</u> | | | | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>garage on home premises</u> | | 20f. CITY, TOWN, OR LOCATION <u>Fenton</u> | | COUNTY <u>Jefferson</u> | | STATE <u>Missouri</u> |
| 21. I attended the deceased from _____, to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE (Degree or title) <u>Raymond H. ... Coroner</u> | | | | 22b. ADDRESS <u>Clayton, Mo.</u> | | 22c. DATE SIGNED <u>12/3/59</u> | |
| 23a. BURIAL, CREMATION OR REMOVAL (Specify) <u>burial</u> | | 23b. DATE <u>11/18/1959</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>National Cemetery</u> | | 23d. LOCATION (City, town, or county) (State) <u>St. Louis Co., Mo.</u> | | |
| 24. FUNERAL DIRECTOR ADDRESS <u>J L Ziegenhein & Sons 7027 Gravois</u> | | | | 25. DATE RECD. BY LOCAL REG. <u>11-16-59</u> | | 26. REGISTRAR'S SIGNATURE <u>John B. Murphy M.D.</u> | |

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 me

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Donald E. Bering

Licensed Embalmer No. 4863

P. O. Address 7027 Howard

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.