

318

1003

-61-010471  
STATE FILE NUMBER

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

3410

Filed APR 14 1961

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>3723 Page Blvd.</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>3723 Page Blvd.</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <b>Lucille</b> Middle <b>Blake</b> Last <b>Blake</b>				4. DATE OF DEATH Month <b>4</b> Day <b>8</b> Year <b>1961</b>									
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Colored</b>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>7-12-1896</b>		9. AGE (last birthday) <b>64</b>		IF UNDER 1 YEAR Months <b>8</b> Days <b>26</b>		IF UNDER 24 HR Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (City and state or country) <b>Tennessee</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>					
13a. FATHER'S NAME <b>William Wright</b>				13b. MOTHER'S MAIDEN NAME <b>Madallia Haraway</b>				14. NAME OF HUSBAND OR WIFE <b>Luther Blake</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT <b>Luther Blake</b>		Address <b>3723 Page Avenue</b>					
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 interstitial nephritis, mitral insufficiency, chronic coma for several days &amp; senility.</i> DUE TO (b) _____ DUE TO (c) _____ 592X 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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown													
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.)									
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 <i>Jan 2 - 61</i> to <i>Apr 8 - 61</i> and last saw her alive on <i>Apr 7 - 61</i> Death occurred at <i>4:30 PM</i> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <i>Erskine D. Proctor M.D.</i> (Degree or title)						22b. ADDRESS <i>3100<sup>th</sup> Lucas, City 3</i>			22c. DATE SIGNED <i>Apr 10/61</i> (State)				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>4-14-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Washington Park</b>				23d. LOCATION (City, town, or county) <b>St. Louis County, Missouri</b>					
24. FUNERAL DIRECTOR <b>Ellis Funeral Home, Inc.</b>				ADDRESS <b>2820 Stoddard St.</b>		25. DATE RECD. BY LOCAL REG. <b>APR 10 1961</b>		26. REGISTRAR'S SIGNATURE <i>Lead Smith, M.D.</i>					

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

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 Yulston E. Culkin

Licensed Embalmer No. 4198  
P. O. Address Pharos, N

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.