

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-009022

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 544 Registrar's No. 593

VS 300  
Rev. 4/59

14003

24038

3

4 1

5 0

6

7 0

8 0

9770.5

10

11

1244-0

13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH MAR 2 1962

a. COUNTY St. Louis

b. CITY (If outside corporate limits, give TOWNSHIP only) Kirkwood Length of stay in lb 27 min.

c. FULL NAME OF (If NOT in hospital, give location) St. Joseph Hospital Inside Limits Yes  No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE Mo. b. COUNTY St. Louis

c. CITY OR TOWN Rock Hill Inside Limits Yes  No

d. STREET ADDRESS # 14 Hardith Ct. (If outside give location) Reside on Farm Yes  No

3. NAME OF DECEASED First Elizabeth Middle Blakeman Last Blakeman

4. DATE OF DEATH Month 2 Day 18 Year 62

5. SEX female 6. COLOR OR RACE white 7. Married  Never Married  Widowed  Divorced

8. DATE OF BIRTH 2/18/62 9. AGE (last birthday) Months 27 Days 27 Hours 27 Min. 27

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) — 10b. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (City and state or country) Kirkwood, Mo 12. CITIZEN OF WHAT COUNTRY USA

13a. FATHER'S NAME John D. Blakeman 13b. MOTHER'S MAIDEN NAME Joann Phillips 14. NAME OF HUSBAND OR WIFE —

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service) — 16. SOCIAL SECURITY NO. — 17. INFORMANT Mr. John Blakeman Address —

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Hydrops fetalis or fluoblastosis

DUE TO (b) No immunization

DUE TO (c) —

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Primaturity; Natural bleeding

PART III. If deceased was female was there a pregnancy in last 90 days.  Yes  No  Unknown

19. WAS AUTOPSY PERFORMED? YES  NO  20a. ACCIDENT  SUICIDE  HOMICIDE  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  NOT WHILE AT WORK  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 12:21 pm 2/18/62 to 12:48 pm 2/18/62 and last saw her alive on — Death occurred at 12:48 pm m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) — 22b. ADDRESS 3915 Watson Rd, Springfield, Ill 22c. DATE SIGNED 2/18/62

23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL 23b. DATE 2-20-62 23c. NAME OF CEMETERY OR CREMATOR Calvary Cemetery 23d. LOCATION (City, town, or county) (State) Springfield, Ill

24. FUNERAL DIRECTOR Chas. Kukulovic, 900 S. 6th St, Springfield, Ill ADDRESS — DATE RECD. BY LOCAL REG. 2-19-62 25. REGISTRAR'S SIGNATURE —

USE BLACK INK OR TYPEWRITER RIBBON

**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 \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

**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.