

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

62-025402

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 317

Primary Registration District No. 531

Registrar's No. 1719

FILED JUN 20 1962

VS 300
Rev. 4/59

14006

24006

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

USE BLACK INK
OR
TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

| | | | |
|--|---|---|--|
| 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>St Louis</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) <u>University City</u> | | Length of stay in lb <u>37 YRS</u> | c. CITY OR TOWN <u>University City</u> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>6624 PERSHING</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>6624 PERSHING</u> |
| 3. NAME OF DECEASED (Type or print) First <u>LEONARD</u> Middle <u>C.</u> Last <u>BLAKE</u> | | 4. DATE OF DEATH Month <u>6</u> Day <u>8</u> Year <u>62</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>9-29-1885</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ADVERTISING MANAGER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>---</u> | 9. AGE (last birthday) <u>77</u> |
| 11. BIRTHPLACE (City and state or country) <u>Caseyville ILL</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | |
| 13a. FATHER'S NAME <u>CHARLES BLAKE</u> | | 13b. MOTHER'S MAIDEN NAME <u>JULIA WERNER</u> | 14. NAME OF HUSBAND OR WIFE <u>CORINNE</u> |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>UNKNOWN</u> | 17. INFORMANT <u>Corinne Blake</u> Address <u>6624 Pershing</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>Coronary Thrombosis</u> DUE TO (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u> <u>2 yrs</u> |
| 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 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 <u>Feb 1960</u> to <u>present</u> and last saw <u>her</u> live on <u>Jan 3, 1962</u> Death occurred at <u>11:00 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) <u>Robert M. Smith MD</u> | | 22b. ADDRESS <u>114 N Taylor</u> | 22c. DATE SIGNED <u>6/9/62</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u> | 23b. DATE <u>6-9-62</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Caseyville Cem.</u> | 23d. LOCATION (city, town, or county) (Specify) <u>Caseyville ILLINOIS</u> |
| 24. FUNERAL DIRECTOR <u>Schroepfel</u> Address <u>Collinsville</u> | | 25. DATE RECD. BY LOCAL REG. <u>6-9-62</u> | 26. REGISTRAR'S SIGNATURE <u>John B. Mumfry MD</u> |

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

Frank Prokeff

Licensed Embalmer No.

4356

P. O. Address

St Louis Mo

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.