

18917

DEPARTMENT OF COMMERCE  
HEALTH DIVISION

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. ....

Registration District No. 784

Primary Registration District No. 17

Registrar's No. 1182

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

96  
7  
4

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Webster Groves  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
235 Old Orchard Av.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis

(c) City or town Webster Groves  
(If outside city or town limits, write "RURAL")

(d) Street No. 235 Old Orchard Av.  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Sarah F. Blake

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 28th  
year 1942 hour 10 minute 30 A.M.

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced 2 W

6. (b) Name of husband or wife John W. Blake 6. (c) Age of husband or wife if alive DECEASED years

7. Birth date of deceased August 7. 1860  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 5/25 1942 to 5/28 1942  
that I last saw h.PT alive on 5/28 1942  
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>81</u>	<u>9</u>	<u>27</u>	hr. _____ min. _____

Immediate cause of death Cerebral hemorrhage

Due to Cerebral Arteriosclerosis

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

9. Birthplace St. Louis Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

Major findings: Of operations 83a

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

MOTHER FATHER

12. Name Peter Kelly

13. Birthplace Ireland 4  
(City, town, or county) (State or foreign country)

14. Maiden name Margaret Campbell

15. Birthplace Ireland 4  
(City, town, or county) (State or foreign country)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_  
(Specify type of place)

While at work? \_\_\_\_\_ Means of injury 0?

23. Signature J.P. Ryan (M. D. or other) \_\_\_\_\_  
Address 671 E. Big Bend Date signed 5/30/42

16. (a) Informant Mr. Thomas Lorenz  
(b) Address 231 Old Orchard Av.

17. (a) Burial (b) Date thereof June 1, 1942  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director M.P. Croghan  
(b) Address 7146 Manchester Ave.

19. (a) MAY 30 1942 (b) E. McCarroll  
(Date received local registrar) (Registrar's signature)

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**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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

*Guy Wilkinson*

Licensed Embalmer No.....

*3875*

P. O. Address.....

*4704 Washington*

**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 this body is not embalmed, fact should be so stated above.**