

No. 2  
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5-17-39  
X35671

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

17414

FILED JUN 5 1944

State File No.

Registration District No.

Primary Registration District No. 1000

Registrar's No. 555

1. PLACE OF DEATH:

(a) County Buchanan  
(b) City or town St Joseph  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: St Joseph's Hosp. A  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 5 wks (Specify whether)  
In this community 25 yrs (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan  
(c) City or town St Joseph (If outside city or town limits, write "RURAL")  
(d) Street No. 1518 Grand (If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country 0 7

3. (a) PRINT FULL NAME David Franklin Blakely

3. (b) If veteran, name war  
3. (c) Social Security No. 500-07-2084

4. Sex Male  
5. Color or race white  
6. (a) Single, widowed, married, divorced, widowed  
6. (c) Age of husband or wife if alive years  
7. Birth date of deceased Dec 10 1870 (Month) (Day) (Year)

8. AGE: Years 73 Months 3 Days 16  
If less than one day hr. min.

9. Birthplace Rnd 1 (City, town, or county) (State or foreign country)

10. Usual occupation laborer

11. Industry or business

12. Name unknown  
13. Birthplace (City, town, or county) (State or foreign country)  
14. Maiden name  
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Earl Maddox

(b) Address St Joseph Mo

17. (a) Burial (b) Date thereof 3-29-44 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ashland Cem.

18. (a) Signature of funeral director: FLEEMAN & SON, INC.

(b) Address St Joseph Mo

19. (a) 3/29/44 (Date received local registrar) (b) Helen A. Pickle (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 26  
year 1944 hour 12 minute 50 P.M.  
21. I hereby certify that I attended the deceased from Feb 23 1944 to March 26 1944  
that I last saw him alive on March 26 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Pyonephrosis  
Duration short

Due to Fracture of 11 dorsal Vertebra  
Due to

Other conditions (Include pregnancy within 3 months of death)  
Major findings: Of operations  
Of autopsy

Duration  
short  
T. med

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

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?

While at work? (Specify type of place)  
(e) Means of injury

23. Signature [Signature] (M. D. or other)  
Address [Address] Date signed 3/27/44

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

MOTHER FATHER

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.....

.....  
working under my personal supervision.

~~Registered Apprentice No.~~.....

Signed.....

Licensed Embalmer No. *3308*

P. O. Address..... *St Joseph, 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 this body is not embalmed, fact should be so stated above.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

1. X36930

FILED JUN 12 1944  
Registration District No. 1000

Primary Registration District No. 1000

Registrar's No. ....

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St. Joseph  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
(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 \_\_\_\_\_ (b) County \_\_\_\_\_

(c) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_  
(If rural, give location)

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

3. (a) PRINT FULL NAME David F. Blakely

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March 1944 Year  
Day \_\_\_\_\_ Hour \_\_\_\_\_ Minute \_\_\_\_\_ M.

4. Sex m

5. Color or race w

6. (a) Single, widowed, married, divorced w

6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased Dec 10 1900  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ and that death occurred on the date and hour stated above.  
Immediate cause of death pyonephrosis  
Duration short

8. AGE: Years 43 Months 3 Days 6 (less than one day \_\_\_\_\_ min.)

Due to Fracture of 11 dorsal vertebra

9. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

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

10. Usual occupation \_\_\_\_\_

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

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

Major findings: Of operations \_\_\_\_\_

12. Name \_\_\_\_\_

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

13. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

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

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

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

16. (a) Informant \_\_\_\_\_

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

(b) Address \_\_\_\_\_

(b) Date of occurrence February 23, 1944

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Where did injury occur? St. Joseph, Buchanan Co. Mo.  
(City or town) (County) (State)

(c) Place: burial or cremation \_\_\_\_\_

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

18. (a) Signature of funeral director \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury Free from

(b) Address \_\_\_\_\_

23. Signature Gustav H. Carr (M. D. or other)

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

Address St. Joseph, Mo. Date signed \_\_\_\_\_

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

SUPPLEMENTARY

17414