

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35147

State File No.

XC-1678 86 51

REG # 335 SL 334
FILED OCT 26 1954

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **9214**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE ILLINOIS b. COUNTY ST. CLAIR	
b. CITY (If outside corporate limits, write RURAL and give township) 915 N. Grand, St. Louis, Mo.		c. CITY OR TOWN E. ST. LOUIS	
c. LENGTH OF STAY (in this place) 189 Days		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION Veterans' Hospital		e. STREET ADDRESS (If rural, give location) 549 N. 32nd, E. St. Louis, Ill	

3. NAME OF DECEASED a. (First) WILLIAM H. b. (Middle) BLAKE c. (Last) BLAKE			4. DATE OF DEATH (Month) (Day) (Year) 10-9-1954		
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) DIVORCED	
8. DATE OF BIRTH 1-29-1886		9. AGE (in years last birthday) 67		IF UNDER 1 YEAR: Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY UNKNOWN		11. BIRTHPLACE (City and State or Foreign Country) / COLLINSVILLE, ILLIS	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME JOSEPH W. BLAKE		13b. MOTHER'S MAIDEN NAME FANNIE VOELKER	
14. NAME OF HUSBAND OR WIFE NONE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW-1		16. SOCIAL SECURITY NO. 348-05-3473	
17. INFORMANT'S SIGNATURE OR NAME VA HOSP. RECORDS, ST. LOUIS, MO.		18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) BRONCHOPNEUMONIA DUE TO UNDETERMINED CAUSE		INTERVAL BETWEEN ONSET AND DEATH	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) BRONCHOPNEUMONIA DUE TO UNDETERMINED CAUSE		19. DATE OF OPERATION VA		19b. MAJOR FINDINGS OF OPERATION THROMBOSIS OF RIGHT CEREBRAL ARTERIES	
19a. DATE OF OPERATION VA		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify)	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. VA	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 491X		22. I hereby certify that I attended the deceased from 4-3-54 , 19___, to 10-9-54 , 19___, and that death occurred at 11:00A m., from the causes and on the date stated above.	

23a. SIGNATURE Leonard J. Kopp (Degree or title) M.D.		23b. ADDRESS St. Louis, Missouri		23c. DATE SIGNED 10-9-54	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 10/12/54		24c. NAME OF CEMETERY OR CREMATORY Greenwood	
24d. LOCATION (City, town, or county) (State) Caseville Twp., Ill.		25. FUNERAL DIRECTOR'S SIGNATURE Chas. Burke		ADDRESS E. St. Louis,	

DATE REC'D BY LOCAL REG. 007 11 1954		REGISTRAR'S SIGNATURE Carl Smith		25. FUNERAL DIRECTOR'S SIGNATURE Chas. Burke	
ADDRESS E. St. Louis,		ADDRESS Illinois		3. (Licensed Embalmer's Statement on Reverse Side)	

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was
by me, or by, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....
Chas Burke

Licensed Embalmer No.....2

P. O. Address E. St. ... Lau
Illinois

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
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.