Health, Welfare Public Service

300
-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-005425
STATE FILE NUMBER 451

FILED FEB 17 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) Kansas City — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) St. Mary's Hosp — Length of stay in lb Life

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Jackson
c. CITY OR TOWN Kansas City — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) 5050 Oak — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First MAXWELL Middle Last BLAKE
4. DATE OF DEATH Month 1 Day 22 Year 59

5. SEX Ma
6. COLOR OR RACE Wh
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH 11-15-1877
9. AGE (In years last birthday) 81 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret Diplomat
10b. KIND OF BUSINESS OR INDUSTRY US State Dept.
11. BIRTHPLACE (City and state or country) Kansas City, Mo.
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME John T. Blake
13b. MOTHER'S MAIDEN NAME Annie Maxwell
14. NAME OF HUSBAND OR WIFE Rosita A.Blake

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) XX
16. SOCIAL SECURITY NO. None
17. INFORMANT Address Elisha R.Blake, 4707 Grand, K.C. Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Amebic Abscess. — INTERVAL BETWEEN ONSET AND DEATH Uncertain
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Amebiasis – Ulceration Coecum — "
DUE TO (c) Amebae Histolitica — "
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 60
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 6-12-1957, to 1-22-59 and last saw ~~her~~ him alive on 1-21-59
Death occurred at 7:45 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) W. A. Myers, MD.
22b. ADDRESS 1115 Grand Ave Kansas City Mo
22c. DATE SIGNED 1-24-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 1-26-1959
23c. NAME OF CEMETERY OR CREMATORY Mt.Washington
23d. LOCATION (City, town, or county) Kansas City (State) Mo

24. FUNERAL DIRECTOR ADDRESS Wagner Funeral Home, K C Mo
25. DATE RECD. BY LOCAL REG. 1-24-59
26. REGISTRAR'S SIGNATURE Neva Minshall

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

W. A. Myers

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 Thomas A. Kuehler

Licensed Embalmer No. 4995

P. O. Address K. C., 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.