

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

XC 21778252

SL-26659

5314 **62-020188**  
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. \_\_\_\_\_

**FILED MAY 31 1962**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, institution; Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St Louis</b>		Length of stay in lb <b>250 Days</b>	c. CITY OR TOWN <b>St Louis</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Vets Adm Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>9559 Bataan</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) <b>CARL I. BLOK</b>			4. DATE OF DEATH Month <b>5</b> Day <b>25</b> Year <b>62</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>5/8/19</b>	9. AGE (last birthday) <b>43</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plasterer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>George Robertson Pl. Co.</b>		11. BIRTHPLACE (City and state or country) <b>Grand Rapids, Mich</b>	
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13a. FATHER'S NAME <b>Irving Blok</b>		13b. MOTHER'S MAIDEN NAME <b>Cecelia Hornberger</b>	
14. NAME OF HUSBAND OR WIFE <b>Clara Blok (wife)</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WS II</b>		16. SOCIAL SECURITY NO. <b>Unk</b>	
17. INFORMANT <b>Clara Blok (wife)</b>		17. ADDRESS <b>See 2 Above</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Massive Upper Gastrointestinal Hemorrhage</b>			<b>Unknown</b>
DUE TO (b) <b>Ulceration of Gastrointestinal Tract</b>			<b>Unknown</b>
DUE TO (c) <b>Lymphosarcoma</b>			<b>Unknown</b>

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	
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)	
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20c. TIME OF INJURY Hour <b>VA</b> Month, Day, Year <b>9/18/61</b> a.m. p.m.	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 <b>VAH, St Louis Mo</b>	COUNTY <b>St. Louis Co., Mo.</b>	STATE <b>Mo.</b>
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21. attended the deceased from <b>9/18/61</b> to <b>5/25/62</b> and last saw him alive on <b>5/25/62</b> Death occurred at <b>4:40 AM</b> on the date stated above, and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE <b>GUILLES M. DESMARAIS</b> (Degree or title) <b>MD.</b>	22b. ADDRESS <b>VAH, St Louis Mo</b>	22c. DATE SIGNED <b>5/25/62</b>

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>5-28-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>National</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis Co., Mo.</b>
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24. FUNERAL DIRECTOR <b>Kriegshauser</b>	ADDRESS <b>9450 Olive St. Rd.</b>	25. DATE RECD. BY LOCAL REG. <b>MAY 26 1962</b>	26. REGISTRAR'S SIGNATURE <b>Roan Smith, M.D.</b>
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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

83

USE BLACK INK OR TYPEWRITER RIBBON

STATE OF NEW YORK

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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 \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed R. W. Stovessand

Licensed Embalmer No. 4007

P. O. Address \_\_\_\_\_

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.