

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-032285

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

1003

8433

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. _____ Registrar's No. _____

FILED SEP 10 1962

VS 300
Rev. 4/59
1
2 <u>211</u>
3
4 <u>3</u>
5 <u>2</u>
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7 <u>1</u>
8 <u>2</u>
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11
12 <u>90-0</u>
13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis, Mo.</u>		Length of stay in 1b	c. CITY OR TOWN <u>St. Louis, Mo. Ave.</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>4449 Garfield Ave.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>4449 Garfield Ave.</u>
3. NAME OF DECEASED (Type or print) First <u>Laura</u> Middle Last <u>Blakley</u>		4. DATE OF DEATH Month <u>8</u> Day <u>28</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>C</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12-10-1896</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>nil</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) <u>65</u>
11. BIRTHPLACE (City and state or country) <u>Mississippi</u>		12. CITIZEN OF WHAT COUNTRY	
13a. FATHER'S NAME <u>Green Bell</u>		13b. MOTHER'S MAIDEN NAME <u>Adline ?</u>	14. NAME OF HUSBAND OR WIFE <u>Ross Blakley</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <u>Mary Sutton</u> Address <u>4449 Garfield Ave.</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 mo.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Hypertensive-Cardio-vascular disease</u>			
DUE TO (c) <u>443 x</u>			
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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)	
20c. TIME OF INJURY Hour, a.m. p.m. Month, Day, Year <u>No history of injury.</u>			
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	COUNTY STATE
21. I attended the deceased from <u>Aug. 24, 62</u> to <u>Aug. 28, 62</u> and last saw her alive on <u>Aug. 28, 1962</u> . Death occurred at <u>2:30 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22. SIGNATURE <u>Blair M. Carter, M.D.</u> (Degree or title)		22b. ADDRESS <u>1507 Belle Glade St. Louis 13, Mo.</u>	22c. DATE SIGNED <u>8-29-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>9/1/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Washington Park Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis, County Mo.</u>
24. FUNERAL DIRECTOR <u>A. F. Walton</u> ADDRESS <u>2707 Stoddard St.</u>		25. DATE RECD. BY LOCAL REG. <u>AUG 30 1962</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>

USE BLACK INK OR TYPEWRITER RIBBON

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 Arthur L. Heilbard

Licensed Embalmer No. 4221

P. O. Address 3100 Easton Ave

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.