

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE



Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 453163-032144 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB AMENDED

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Kansas City</u>		Length of stay in 1b <u>23 yrs.</u>	c. CITY OR TOWN <u>Kansas City</u> Inside Limits <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>6141 Oak</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>6141 Oak Street</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Elisha Roman Blake</u>			4. DATE OF DEATH Month Day Year <u>August 12 1963</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10/15/26</u>
9. AGE (last birthday) <u>36</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance Adjuster</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance Co.</u>	11. BIRTHPLACE (City and state or country) <u>Tangier Morocco</u>
12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>		13a. FATHER'S NAME <u>Maxwell Blake</u>	
13b. MOTHER'S MAIDEN NAME <u>Rosita Abrines</u>		14. NAME OF HUSBAND OR WIFE <u>Lois Sue Blake</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>WW 11</u>	
17. INFORMANT <u>Mrs. Sue Blake</u>		Address <u>6141 Oak K.C., Mo.</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Branchopneumonia</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> Conditions, if any, which gave rise to above cause (b), stating the underlying cause last. DUE TO (b) <u>Glioma of brain involving Thalamus</u> DUE TO (c) _____ 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			
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.)	
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year		
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>March 1963</u> to <u>present</u> and last saw her alive on <u>Aug 12, 1963</u> Death occurred at <u>8:15 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>John S. Myers M.D.</u> (Degree or title)		22b. ADDRESS <u>815 Shukert Bldg. K.C., Mo.</u>	22c. DATE SIGNED <u>8-14-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8/16/1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mount Washington</u>	23d. LOCATION (City, town, or county) (State) <u>Kansas City Missouri</u>
24. FUNERAL DIRECTOR <u>Wagner Funeral Home</u>	ADDRESS <u>K.C., Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>8-14-63</u>	26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>

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 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTEAD OF  
 SHOULD READ  
 ITEM NO.  
 DATE AMENDED  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 BY AFFIDAVIT OF John S. Myers

USE BLACK INK OR TYPEWRITER RIBBON

John R. Myerson  
815 Student Bldg.  
1115 - Kansas  
No. 23925  
April 4 PM

**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 Abrie R. H. Hancefield

Licensed Embalmer No. 4159

P. O. Address Shawano County 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.