

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

1. PLACE OF DEATH

County.....
Township.....
City..... *St. Louis*

Registration District No. **791**
Primary Registration District No. **1003**

File No. **35171**
Registered No. **10134**
St. Ward.....

2. FULL NAME

Helen Blanzner
(a) Residence. No. *7115 Vermont a* St., Ward.....
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Single*

5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Nov 11-18 63*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
64 11 3

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Home Work*
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Missouri*

10. NAME OF FATHER *Unknown*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *Unknown*

12. MAIDEN NAME OF MOTHER *Unknown*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *Unknown*

14. INFORMANT *Emil Vega*
(Address) *7115 Vermont a*

15. FILED *11 16 1928* *Max B. Starkeoff*
REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Oct 14 1928*

17. I HEREBY CERTIFY That I attended deceased from *Sept 16* 19*28* to *Oct 14* 19*28* that I last saw him alive on *Oct 15* 19*28*, and that death occurred, on the date stated above, at *8:30 A* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Hemorrhage due to Hypertension

CONTRIBUTORY (SECONDARY) *Chronic Interstitial Nephritis*
(duration) *1* yrs. *1* mos. *da.*

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH *1211*

0 DID AN OPERATION PRECEDE DEATH. *No* DATE OF

WAS THERE AN AUTOPSY *No*

WHAT TEST CONFIRMED DIAGNOSIS *Urinalysis*
(Signed) *H. H. [Signature]* M. D.
Oct 15, 1928 (Address) *3860 S Broadway*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *New Parken* DATE OF BURIAL *10-16 1928*

20. UNDERTAKER *Southern* ADDRESS *7315 S. Brady*

K. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. WHITE PLAINLY, WITH UNFADING INK—THIS IS AN EMERGENCY RECORD.

Bdy & Neobanks 12