

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

Do not use this space.

1. PLACE OF DEATH JUL 12 1935

21220

County _____ Registration District No. 791
 Township _____ Primary Registration District No. 1003
 City St. Louis (No. 6709 Washington)

File No. _____
 Registered No. 5155
 St. _____ Ward _____

2. FULL NAME Lucinda M. Blum Blank
 (a) Residence, No. 6209 Washington St., 5 Ward.
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 12 1935

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF John Blank

22. I HEREBY CERTIFY, That I attended deceased from June 3, 1935, to June 12, 1935
 I last saw her alive on June 3, 1935. Death is said to have occurred on the date stated above, at 12:30 a.m.

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 25 - 1860

The principal cause of death and related causes of importance were as follows:

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
74 9 17

Lobar Pneumonia etc Date of onset 6/2

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. at home

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

Other contributory causes of importance: Chr Myocardite 108 1930

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Wasson Mo

13. NAME Walter M. Blum

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Frankfort Ky.

15. MAIDEN NAME Elizabeth Camp

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT Spencer Merrill (ADDRESS) No 208 Washington

18. BURIAL, CREMATION OR REMOVAL PLACE Oak Grove DATE June 14 1935

19. UNDERTAKER Ally and Sons (ADDRESS) 6175 - 18th St

20. FILED JUN 13 1935 19 J. F. Bredeck Registrar.

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? No Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?
 If so, specify _____ (Signed) M. E. Camp, M. D.
 (Address) 6209 Washington

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. 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.

Wm Geo. Brown
5249 Raymond