

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.

REC'D APR 12 1939

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

791
1003

8553
Do not use this space.

2318

1. PLACE OF DEATH

(a) County Registration District No.
(b) Township Primary Registration District No.
(c) City St. Louis (d) Street No. City Hospital No. 1 St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

D. 17076 453
Albert Bland
(a) Residence, No. 6629 Tholozan (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city) 3

PERSONAL AND STATISTICAL PARTICULARS

| | | | | |
|---|----------------------------------|---|---|--|
| 3. SEX <u>male</u> | 4. COLOR OR RACE <u>white</u> | 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>married</u> | | |
| 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Irene Bland</u> | | | | |
| 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>June 11 1871</u> | | | | |
| 7. AGE YEARS <u>67</u> | MONTHS <u>67</u> | DAYS <u>8</u> | If LESS than 1 day, hrs. or min. <u>29</u> | |
| 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. | | | | |
| 9. Industry or business in which work was done, as saw mill, bank, etc. <u>laborer</u> | | | | |
| 10. Date deceased last worked at this occupation (month and year) | | | | |
| 11. Total time (years) spent in this occupation | | | | |
| 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Pennsylvania</u> | | | | |
| 13. NAME <u>William Bland</u> | | | | |
| 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Pennsylvania</u> | | | | |
| 15. MAIDEN NAME <u>Donnelly</u> | | | | |
| 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Pennsylvania</u> | | | | |
| 17. INFORMANT <u>Hosp. Info M. Kent</u> (ADDRESS) | | | | |
| 18. BURIAL, CREMATION, OR REMOVAL PLACE <u>CALVARY</u> DATE <u>3-13-39</u> | | | | |
| 19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>MARY S. HAUSER</u> <u>4228 So. Main St. St. Louis</u> | | | | |
| 20. FILED <u>MAR 11 1939</u> <u>J. B. Bland</u> Local Registrar | | | | |

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3/10/39 19

22. I HEREBY CERTIFY, That I attended deceased from 2/21/39 to 3/10/39, 19

I last saw him alive on 3/10/39, 19. Death is said to have occurred on the date stated above, at 6, 05 a.

The principal cause of death and related causes of importance were as follows:
prostate hypertrophy
pelvic abscess
caused by abscess of prostate
Non Venereal

Date of onset

Other contributory causes of importance:
137

Name of operation transurethral prostatectomy Date of 3/7/39
What test confirmed diagnosis? Was there an autopsy? yes

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? 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 Wm. Arthur, M. D.
(Signed) Wm. Arthur
(Address) City Hospital No. 1

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

Registered Apprentice No., working under my personal supervision.

Signed.....



Licensed Embalmer No.

3024

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 this body is not embalmed, above space should be left blank.