

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
SEP 14 1939

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **27420**  
Registrar's No. **6920**

Registration District No. **1791** Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH:  
(a) County **1**  
(b) City or town **St. Louis**  
(c) Name of hospital or institution: **Josephine Hospital**  
(d) Length of stay: In hospital or institution **3 DAYS**  
In this community **79 Years**

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Missouri** (b) County **1**  
(c) City or town **St. Louis**  
(d) Street No. **2020<sup>a</sup>S. 11th St.**  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years

3. (a) PRINT FULL NAME **Mary Blohm 450**  
(b) If veteran, name war **No**  
(c) Social Security No. **No**

4. Sex **Female** 5. Color or race **White**  
6. (a) Single, widowed, married, divorced **Widowed**  
6. (b) Name of husband or wife **John**  
6. (c) Age of husband or wife if alive **--** years  
7. Birth date of deceased **Sept. 28, 1859**

8. AGE:	Years	Months	Days	If less than one day
	<b>79</b>	<b>10</b>	<b>8</b>	hr. _____ min. _____

9. Birthplace **St. Louis Missouri**

10. Usual occupation **Home**

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
12. Name **Rudolph Faenger**  
13. Birthplace **Germany**  
14. Maiden name **Unknown**  
15. Birthplace **Germany**

16. (a) Informant's own signature **Louis Blohm**  
(b) Address **2020<sup>a</sup>S. 11th St.**

17. (a) **Burial** (b) Date thereof **8/11/39**  
(c) Place: burial or cremation **N. St. Marcus**

18. (a) Signature of funeral director **Wacker-Kelderle**  
(b) Address **2331 S. Broadway**

19. (a) **AUG 9 1939** (b) **J. E. Bredbeck**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **Aug.** day **5** year **1939** hour **11** minute **45 A.M.**  
21. I hereby certify that I attended the deceased from **July 26, 1939** to **Aug 5, 1939**

that I last saw him alive on **Aug 5, 1939** and that death occurred on the date and hour stated above.

Immediate cause of death **hypostatic pneumonia unspecified** Duration \_\_\_\_\_

Due to **Chronic myocarditis & acute nephritis & Dropsy.**

Due to **acute nephritis caused by anemia**

Other conditions **hypertension**

Major findings: Of operations **none**

Of autopsy **none**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_  
While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_

23. Signature **Louis F. Murray** (M. D. or other) \_\_\_\_\_  
Address **1931 S. 9<sup>th</sup> St.** Date signed **9-5-39**

OK for burial  
8-15-39  
ESK

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.....

*Robert Wheeler*

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

*Robert Wheeler*

\*Licensed Embalmer No. 2178

P. O. Address *W. Harris 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 this body is not embalmed, above space should be left blank.