

STANDARD CERTIFICATE OF DEATH

34592

State File No.

Registration District No. 1002

Primary Registration District No.

Registrar's No. 9130

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Jewish Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 34 years
(Specify whether years, months or days)

8. (a) PRINT FULL NAME Ruth Blaha
8. (b) If veteran, name war. _____ 8. (c) Social Security No. 425

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Robert Blaha 6. (c) Age of husband or wife if alive 37 years
7. Birth date of deceased Dec 13, 1885 (Month) (Day) (Year) 1904

8. AGE: Years 34 Months 10 Days 10 If less than one day hr. _____ min. _____

9. Birthplace St. Louis, Mo. (City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business Housewife

12. Name Kramer

18. Birthplace Unknown (City, town, or county) (State or foreign country)

14. Maiden name Amelia Long (City, town, or county) (State or foreign country)

15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Robert Blaha
(b) Address 4237 Gertrude Ave.

17. (a) Burial (b) Date thereof Oct 26/39
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation News S. Peter & Paul

18. (a) Signature of funeral director Thos. Kules
(b) Oct 25 1939 2906 Groves

19. (a) Oct 25 1939 (b) J.F. Budech
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis (If outside city or town limits, write "RURAL") 15
(d) Street No. 4237 Gertrude (If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 23
year 1939 hour 5 minute 50 A.M.
21. I hereby certify that I attended the deceased from Mar. 14
1939, to Oct. 23, 1939
that I last saw her alive on Oct. 23, 1939
and that death occurred on the date and hour stated above.

Immediate cause of death Post-partum uterine hemorrhage

Due to _____
Due to _____
Other conditions None
(Include pregnancy within 3 months of death)

Major findings: None
Of operations _____
Of autopsy No autopsy

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically

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? _____ (City or town) (County) (State)
(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 Dr. P.D. Stahl (M. D. or D. O.)
Address 462 N. Taylor Ave Date signed 10/

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.

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.....

WALLACE FITCH.....

Registered Apprentice No.....

working under my personal supervision.

Signed..... Wallace N. Fitch.....

Licensed Embalmer No..... 3859.....

P. O. Address..... 2906 Gravois Ave......

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.