

Registration District No. **791** Primary Registration District No. _____ Registrar's No. **10979**

1. PLACE OF DEATH: **1003**
(a) County **St. Louis Mo**
(b) City or town _____
(c) Name of hospital or institution **Lutheran Hospital**
(d) Length of stay: _____
In this community _____ years, months or days **11 5 5**

3. (a) PRINT FULL NAME: CHARLES BLUMENSTEIN.
8. (b) If veteran, name war: No **8. (c) Social Security No. 88**
4. Sex: Male **5. Color or race: White** **6. (a) Single, widowed, married, divorced: Widowed**
6. (b) Name of husband or wife: Heine **6. (c) Age of husband or wife if alive: 68** years
7. Birth date of deceased: Jan 12 1871. (Month) (Day) (Year)

8. AGE: Years **68** Months **11** Days **10** If less than one day hr. min.

9. Birthplace: St. Louis, Ill. (City, town, or county) (State or foreign country)
10. Usual occupation: Barber

11. Industry or business:
12. Name: Samuel Blumenstein
13. Birthplace: Switzerland (City, town, or county) (State or foreign country)
14. Maiden name: Elizabeth Heine
15. Birthplace: Switzerland (City, town, or county) (State or foreign country)

16. (a) Informant's own signature: Mena Blumenstein
(b) Address: 3209 Northford

17. (a) Burial, cremation, or removal: Burial **(b) Date thereof: Dec 26 1939** (Month) (Day) (Year)
(c) Place: burial or cremation: New Berlin Ill.

18. (a) Signature of funeral director: J. J. Quinn
(b) Address: 3389 Union St

19. (a) DEC 25 1939 (b) J. J. Brubaker (Date received local registrar) (Name of signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo** (b) County _____
(c) City or town **St. Louis** **16** (If outside city or town limits, write "RURAL")
(d) Street No. **3209 Northford St** (If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 12 day 22 year 1939 hour 6:20 minute P. M.
21. I hereby certify that I attended the deceased from 12/20/39 12/20/39, 19 to 12/22/39 1939
that I last saw him alive on **Dec 22 1939** and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage** Duration **2 hours**
Due to **Arterial Sclerosis**

Due to _____
Other conditions **Hyper Tension** (Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: Of operations _____
Of autopsy _____
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: A. J. Thompson (M.D. or other)
Address **4439 San Francisco** Date signed **12/26/39**

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed Clement McNearf

Licensed Embalmer No. 3732

P. O. Address St. Louis

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.