

791

1003

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registrar's No. **7937**

1. PLACE OF DEATH:

(a) County \_\_\_\_\_

(b) City or town **St. Louis**  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **2738 Burd Ave.**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ **2**  
(Specify whether

In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County \_\_\_\_\_

(c) City or town **St. Louis** **26**  
(If outside city or town limits, write "RURAL")

(d) Street No. **2738 Burd Ave.**  
(If rural, give location)

(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME

**Frank J. Blome**

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. **None**

4. **Male**

5. Color or race **White**

6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Josie L. Blome**

6. (c) Age of husband or wife if alive **65** years

7. Birth date of deceased **Apr. 13 1861**  
(Month) (Day) (Year)

8. AGE: Years **79** Months **5** Days **10** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace **Ind.**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Laborer**

11. Industry or business **Retired**

12. Name **Unknown**

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

14. Maiden name **Unknown**

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

16. (a) Informant **Josie L. Blome**

(b) Address **2738 Burd Ave.**

17. (a) **Burial** (b) Date thereof **9-25-40**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Memorial Park Cem.**

18. (a) Signature of funeral director **Drehmann-Harral**

(b) Address **1905 Union Blvd.**

19. (a) **SEP 24 1940** (b) **J. F. Bergman**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept.** day **23** year **1940** hour **12** minute **30** A.M.

21. I hereby certify that I attended the deceased from **September 16**, 19**40**, to **Sept. 23**, 19**40**.

that I last saw him **alive on Sept. 22**, 19**40**, and that death occurred on the date and hour stated above.

Immediate cause of death **arteriosclerosis**

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions **Paralysis (right)**  
(Include pregnancy within 3 months of death)

Major findings: **Cerebral hemorrhage of pteryx**

Of operations \_\_\_\_\_

Of 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 **H. F. Bergman** (M. D. or other) **M.D.**

Address **3720 Washington** Date signed **9/24/40**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

8720 Washington  
9-10 a.m.  
5601 St. Francis  
evening.

**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 Warren A. Carver

Licensed Embalmer No. 3534

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, fact should be so stated above.