No. 2
-10-39
7-39
X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 43778 921 6

FILED JAN 8 1941

Registration District No. 184

Primary Registration District No. 101

Registrar's No. 2449

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

1. PLACE OF DEATH:

(a) County St Louis

(b) City or town Clayton (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St Louis County Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ (Specify whether In this community ____ years, months or days) 1

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St Louis

(c) City or town Oakland (If outside city or town limits, write "RURAL")

(d) Street No. Louisville & Big Bend Rds (If rural, give location)

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

3. (a) PRINT FULL NAME Frank Block

3. (b) If veteran, name war ____

3. (c) Social Security No. ____

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Dec

6. (b) Name of husband or wife ____

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

7. Birth date of deceased no one knows (Month) (Day) (Year)

8. AGE: Years | Months | Days | If less than one day ____ hr. ____ min.

age about 61 yrs

9. Birthplace Hannibal (City, town, or county) Mo (State or foreign country) 0

10. Usual occupation nil 6

11. Industry or business ____ 6

FATHER
12. Name John Block
13. Birthplace ____ (City, town, or county) Germany (State or foreign country)

MOTHER
14. Maiden name Margaret A. Roth
15. Birthplace ____ (City, town, or county) Germany (State or foreign country)

16. (a) Informant Mrs. Laura Tojas
(b) Address 1734 Spruce St. Granite City

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-29-40 (Month) (Day) (Year)
(c) Place: burial or cremation Hannibal Mo

18. (a) Signature of funeral director Louis H Bopp Inc
(b) Address Kirkwood Mo

19. (a) DEC 26 1940 (Date received local registrar) (b) T R Meyer M D Dr P H (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 24 year 1940 hour 8:35 minute A M.

21. I hereby certify that I attended the deceased from 12-22-40, 19__, to 12-24-40, 19__; that I last saw him alive on 12-24-40, 19__; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Tuberculous Meningitis	2 days
Due to Bilateral Pulmonary Tuberculosis	?
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations ____
Of autopsy Generalized Meningitis - Bilateral Pul. Tb c cavitation

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? ____ (Specify type of place)
While at work? ____ (e) Means of injury ____

23. Signature Leersall (M. D. or other) 1
Address St Louis Co. Hosp. Date signed ____

(Licensed Embalmer's Statement on Reverse Side)

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 Louis H Bopp, Registered Apprentice No. ..... working under my personal supervision.

Signed Louis H Bopp

Licensed Embalmer No. 921

P. O. Address Kirkwood

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.