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1-5-43
5-17-39
I X36671

FILED DEC 7 1945
318

Registration District No. _____
Primary Registration District No. **1003**

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: **Christian Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2 months**
In this community **43 years** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County _____
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **506 E. Gano Ave**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **John Blasko Sr.**

3. (b) If veteran, name war **None** 3. (c) Social Security No. _____

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Catherine Blasko nee Budie** 6. (c) Age of husband or wife if alive **61** years

7. Birth date of deceased: **September 4, 1881**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	64	2	22	hr. _____ min. _____

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

10. Usual occupation **Dish washer**

11. Industry or business **Christian Hospital**

MOTHER FATHER

12. Name **Unknown**

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

14. Maiden name **Unknown**

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

16. (a) Informant **Mrs Catherine Blasko Jr.**

(b) Address **506 E. Gano Ave**

17. (a) **Burial** (b) Date thereof **11/29/45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **New Bethlehem Cemetery**

18. (a) Signature of funeral director **Math Hermann & Son**

(b) Address **2161 East Fair Ave**

19. (a) **NOV 28 1945** (b) **J. J. Bredbeck**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov.** day **26,** year **1945** hour **11:00 AM** minute _____ M.

21. I hereby certify that I attended the deceased from **Oct 5** 19**45** to **Nov 26** 19**45**
that I last saw him alive on **Nov 26** 19**45** and that death occurred on the date and hour stated above.

Immediate cause of death: **Cedera Carcinoma of Sigmoid** Duration **3 m**

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

Major findings: Of operations _____
Of autopsy **gros. Confirmed Diag.**

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 **Geo. A. Mellis** (M. D. or other) _____

Address **2739 N. Grand** Date signed **11/28/45**

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

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 Gustav W Dietel
Licensed Embalmer No. 4329
P. O. Address St. Louis, 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, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Dec
Registrar's No. 10299

Registration District No. 318 Primary Registration District No. 1003

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:
(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)

3. (a) PRINT FULL NAME John Blasko Sr.
 3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m
 6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive.....

7. Birth date of deceased Sept 4 1904
(Month) (Day) (Year)

8. AGE: Years 64 Months 2 Days 2 If less than one day hr. min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 12. Name.....
 { 13. Birthplace.....
(City, town, or county) (State or foreign country)
 { 14. Maiden name.....
 { 15. Birthplace.....
(City, town, or county) (State or foreign country)

16. (a) Informant.....
 (b) Address.....

17. (a) (Burial, cremation, or removal)..... (b) Date thereof.....
(Month) (Day) (Year)
 (c) Place: burial or cremation.....

18. (a) Signature of funeral director.....
 (b) Address.....

19. (a) JAN 17 1945 J. F. Bredich
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....
 (c) City or town.....
(If outside city or town limits, write "RURAL")
 (d) Street No.....
(If rural, give location)
 (e) Citizen of foreign country?..... (Yes or No)
 If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov Day 26 Year 1945 Hour 10 minute 16 M.
 21. I hereby certify that I attended the deceased from 1945 to 1945 that I last saw him alive on 11/26/45 and that death occurred on the date and hour stated above. Immediate cause of death.....

Due to.....
 Due to.....
 Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:
 Of operations.....
 Of autopsy.....

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..... (M. D. or other).....
 Address..... Date signed.....

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

SUPPLEMENTARY

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

350600