

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH 11615

1 PLACE OF DEATH

County

Township

or

Village

or

City *Sporee* (NO. *City Hospital* St. *9* Ward)

17859

2 FULL NAME *Frank Blante*

Registration District No. *791*

File No.

Primary Registration District No. *1003*

Registered No. *3448*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *male* 4 COLOR OR RACE *white* 5 SINGLE MARRIED WIDOWED OR DIVORCED *Single*
(Write the word)

6 DATE OF BIRTH *June 19 1858*
(Month) (Day) (Year)

7 AGE *60* yrs. *7* mos. *14* ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work *Tailor*
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE *Germany*
(City or town, State or foreign country)

PARENTS
10 NAME OF FATHER *Jetes Blanke*
11 BIRTHPLACE OF FATHER *Germany*
(City or town, State or foreign country)
12 MAIDEN NAME OF MOTHER *Jerdina*
13 BIRTHPLACE OF MOTHER *Germany*
(City or town, State or foreign country)

14 THE MEDICAL OPINION TO THE BEST OF MY KNOWLEDGE
Choran
(Informant)
(Address) *City Hospital*

15 APR - I 1918 *Max B Starkloff*
Filed....., 1918. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *March 31 1918*
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from *March 29 1918*, to *March 31 1918*, that I last saw him alive on *March 30 1918*, and that death occurred, on the date stated above, at *7:10 A.M.*
The CAUSE OF DEATH* was as follows:

Tuberculosis Chronic Pulmonary
(Duration) yrs. *18* mos. ds.

CONTRIBUTORY (Secondary) *Asbestosis*
(Duration) yrs. mos. ds.
(Signed) *Maxwell* M. D.
March 31 1918 (Address) *City Hospital*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted if not at place of death?
Former or usual residence *7306 S. Dolez*

19 PLACE OF BURIAL OR REMOVAL *St. Peter Pauls* DATE OF BURIAL *April 3 1918*

20 UNDERTAKER *Wanda Helding* ADDRESS *2331 No. Bury*

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations, a single word or term on the first line will be sufficient; e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement: Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report

"Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc.; when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL, septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, OR HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

County _____

Township _____

Registration District No. 791

File No. _____

Village _____

Primary Registration District No. 3Registered No. 3448

City _____

-St. _____

Ward _____

(If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME Frank Blauke

PERSONAL AND STATISTICAL PARTICULARS

M COLOR OR RACE W SINGLE MARRIED WIDOWED OR DIVORCED (If write the word) ✓

DATE OF BIRTH _____

(Month) (Day) (Year)

AGE _____

yrs. mos. ds.

If LESS than 1 day, hrs. or min.

OCCUPATION

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE

(City or town, State or foreign country) _____

PARENTS

NAME OF FATHER _____

BIRTHPLACE OF FATHER

(City or town, State or foreign country) _____

MAIDEN NAME OF MOTHER _____

BIRTHPLACE OF MOTHER

(City or town, State or foreign country) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____

1917Max C. Starkoff

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

Mar 31, 1918
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 1918, to _____, 1918,that I last saw h _____ alive on _____, 1918,

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows: Institution

Contributory _____

(SECONDARY)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____

M. D.

(Address) _____

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL _____

DATE OF BURIAL _____

1918

UNDERTAKER

ADDRESS _____

Shackles St.

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

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5191
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