

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

Do not use this space.

42533

1. PLACE OF DEATH

County.....

Registration District No.....

791

Township.....

Primary Registration District No.....

1003

City.....

(No. *Seasons Hosp.*)

File No.....

Registered No.....

11772

St.....

Ward.....

2. FULL NAME

Stunigunda Blum

(a) Residence. No.....

2812 Glendale

St.,

11

Ward.

St. Louis Co. Mo.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U.S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

Nov. 6 - 1840

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

88

-

26

8. OCCUPATION OF DECEASED

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

Seamstress 186A 194R

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

111E

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Germany

10. NAME OF FATHER

Jacob Blum

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Germany

12. MAIDEN NAME OF MOTHER

C. Wieland

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Germany

14.

INFORMANT

Sophia Borcharding

(Address)

2812 Glendale

15.

FILED

1928

Max Estwick

REGISTRAR

3

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

Dec 2nd 19 28

17.

I HEREBY CERTIFY That I attended deceased from *Nov. 22*, 19*28*, to *Dec 2*, 19*28* that I last saw him alive on *Dec 1*, 19*28* and that death occurred, on the date stated above, at *1:30 AM* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

no labor or Crownho #103

Pneumonia

(Hypostatic)

CONTRIBUTORY (SECONDARY)

Fracture of right humerus, falling

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH:

DID AN OPERATION PRECEDE DEATH?

IF YES, STATE OF

WHAT WAS THE CONFIRMED DIAGNOSIS?

(Signed) *J. J. Niebauer M.D.*

Dec 2 19 28 (Address) *3621 N 20th St*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

New Bethlehem

Dec 5 19 28

20. UNDERTAKER

ADDRESS

Hy Leidner Und Co. St. Market

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

