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

Do not use this space.

38762

1. PLACE OF DEATH

County ..... Registration District No. 791 1003 File No. .....

Township ..... Primary Registration District No. ..... Registered No. 11181

City St Louis (No. Christian Hosp. St. ..... Ward)

2. FULL NAME Mary E. Blum

(a) Residence. No. 610 Leland Ave St., 9 Ward. University City 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	White	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 31, 1863

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	66	2	14	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Washington Co.
(STATE OR COUNTRY) Missouri

PARENTS

10. NAME OF FATHER Henley Hahm

11. BIRTHPLACE OF FATHER (CITY OR TOWN) ?
(STATE OR COUNTRY) Germany

12. MAIDEN NAME OF MOTHER Nancy Wheeless

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Don't know.

14. INFORMANT Mr. Manuel Blum
(Address) 610 Leland Ave

15. FILED NOV 16 1929 Max C Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11 - 14 1929

17. I HEREBY CERTIFY, That I attended deceased from 11-12, 1929, to 11-14, 1929 that I last saw h. EY alive on 11-14, 1929 and that death occurred, on the date stated above, at 11 A 30 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Perforation of Bowell Hemorrhage into Bowel 46 C. 1 2 3 A 1 2 3 B (duration) ..... yrs. ..... mos. ? ds.

CONTRIBUTORY (SECONDARY) Carcinoma of the Calcium (duration) ..... yrs. ? mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH .....
DID AN OPERATION PRECEDE DEATH? No DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Physical Exam

(Signed) R C McElvaine, M. D.
, 19 (Address) 4356 Warne

*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
Nashville Ill	11-17 1929
20. UNDERTAKER	ADDRESS
Geo. L. Pleitsch	5966 Easton ave.

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.

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