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

Do not use this space.

File No. 28038

Registered No. 7867

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1093

City St Louis Mo. (No. Lady Hospital St. ..... Ward)

2. FULL NAME Mrs Mabel Blaske

(a) Residence. No. 2915 Benton St., 20 Ward.
(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 Fred Blaske

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 2-1899

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
31	4	2	

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) (STATE OR COUNTRY) St Louis Mo.

PARENTS
10. NAME OF FATHER Wm. Wessler
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) St Charles Mo.
12. MAIDEN NAME OF MOTHER Cora De Roy
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) St. Charles

14. INFORMANT Fred Blaske
(Address) 2915 Benton St

15. AUG -7 1930 FILED ..... 19 ..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 4 1930

17. I HEREBY CERTIFY, That I attended deceased from ..... 19 ..... to ..... 19 ..... that I last saw h. ..... alive on ..... 19 ..... and that death occurred, on the date stated above, at 9:00 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
General Septicaemia
Following Abortion
Self Induced
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED .....
IF NOT AT PLACE OF DEATH .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) Wm V Dever M. D.
8/7 1930 (Address) Coroner

*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
Calvary	Aug 8 1930
20. UNDERTAKER Hy. Leedner	ADDRESS 1417 N. Market

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.