

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

Do not use this space.

1. PLACE OF DEATH

County St. Louis
Township North
City St. Louis (No. _____)

Registration District No. 845
Primary Registration District No. 6108

File No. 28886
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Leola L. Blumens

(a) Residence No. _____ St. _____ Ward _____
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 1 - 1893

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
36 9 19

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

9. BIRTHPLACE (CITY OR TOWN) Union Ark
(STATE OR COUNTRY)

10. NAME OF FATHER Paul Blumens

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Union Ark

12. MAIDEN NAME OF MOTHER Hale Walker

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Union Ark

14. INFORMANT George Blumens
(Address) Reed Springs Mo

15. FILED 8/21/30 L S Sturmate
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 19 1930

17. I HEREBY CERTIFY, That I attended deceased from Aug 1930, to Aug 15 1930, that I last saw him alive on Aug 18 1930, and that death occurred, on the date stated above, at 8:30 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pulmonary T.B.

23 H (duration) 1 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 31 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH Yes

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS None
(Signed) [Signature] M. D.

8/20/30 (Address) Reed Springs Mo
*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 Denkme Cemetery DATE OF BURIAL Aug 20 1930

20. UNDERTAKER Mr. Stubby ADDRESS Reed Springs Mo

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.

1930

