

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

Do not use this space.

37283

3 1930

1. PLACE OF DEATH

County St. Louis Registration District No. 790
 Township _____ Primary Registration District No. 6033
 City Clayton (No. Ritzinger Road) St. _____ Ward _____

2. FULL NAME

Eugenia C. Blanke
 (a) Residence. No. Ritzinger Road Ward _____
 (Usual place of abode)
 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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 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 Cyrus J. Blanke
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 9th 1866
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
63 11 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) Clinton
 (STATE OR COUNTRY) Mo.

10. NAME OF FATHER Albert P. Drowein
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) Germany
 12. MAIDEN NAME OF MOTHER Augusta Muller
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Augusta
 (STATE OR COUNTRY) Mo.

14. INFORMANT G. J. Blanke
 (Address) Ritzinger Road

15. FILED Jun 24 1930 R. W. Sullivan
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 23 1930

17. I HEREBY CERTIFY, That I attended deceased from Jan 1927 to Nov 23 1930, 1930
 that I last saw him alive on Nov 23 1930, and that death occurred, on the date stated above, at 9 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral hemorrhage
 (duration) _____ yrs. mos. 12 ds.

CONTRIBUTORY (SECONDARY) Arteriosclerosis & hypertension (duration) 3 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? Spec. Exam
 (Signed) Samuel B. Grant M. D.
Nov 24 1930 (Address) 3720 Washington

*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 Bellefontaine Cem. DATE OF BURIAL Nov 25 1930

20. UNDERTAKER Haynes ADDRESS 3621 Olive St.

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.

