

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

Do not use this space.

15989

**1. PLACE OF DEATH**

County..... Registration District No. **791**  
 Township..... Primary Registration District No. **1003**  
 City **St. Louis, mo.** (In **Lutheran Hospital** St. \_\_\_\_\_ Ward \_\_\_\_\_)  
 Registered No. **4461**

**2. FULL NAME**

**Blanche Proske Jr.**  
 (a) Residence. No. **8011 M.E. See** St. **24** Ward **St. Louis 00. 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 <b>male</b>	4. COLOR OR RACE <b>W.</b>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <b>single</b>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <input checked="" type="checkbox"/>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <b>4-10-31</b>		
7. AGE	YEARS	MONTHS
		DAYS
		If LESS than 1 day, ..... hrs. or ..... min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer <b>Infant</b>		
9. BIRTHPLACE (CITY OR TOWN) <b>St. Louis, mo.</b> (STATE OR COUNTRY)		
PARENTS	10. NAME OF FATHER <b>Blanche W. Proske</b>	
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) <b>St. Louis, mo.</b> (STATE OR COUNTRY)	
	12. MAIDEN NAME OF MOTHER <b>Melan M. Lange</b>	
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) <b>St. Louis, mo.</b> (STATE OR COUNTRY)		

**MEDICAL CERTIFICATE OF DEATH**

15. DATE OF DEATH (MONTH, DAY AND YEAR) **4-12 1931**  
 17. I HEREBY CERTIFY, That I attended deceased from **April 10**, 19**31**, to **April 12**, 19**31**, that I last saw him alive on **4-12**, 19**31**, and that death occurred, on the date stated above, at **7:00 p. m.**

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

**Pneumonia (lobar)**

**1074**

(duration) yrs. mos. ds.  
 CONTRIBUTORY (SECONDARY) **1074**  
 (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?  
 (Signed) **Victor F. Krippel**, M. D.  
**4-12, 1931** (Address) **Chippewa Trust Bldg.**

\*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.

14. INFORMANT **Clara H. Klein P. n**  
 (Address) **Lutheran Hospital**  
 15. FILED **1931** **M. C. Starker**  
 REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **Concordia**  
 DATE OF BURIAL **4-13 1931**  
 20. UNDERTAKER **H. Schumacher**  
 ADDRESS **3013 Insurance**

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

K. 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.

MARGIN RESERVED FOR BINDING

V. S. NO. 2.

