

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

Do not use this space.

29224

1. PLACE OF DEATH

County St. Francois Registration District No. 773
 Township St. Francois Primary Registration District No. 6018A
 Near City Farmington, Mo. (No. _____) St. _____ Ward _____

File No. _____
 Registered No. 114

2. FULL NAME August R. Blum

(a) Residence. No. De Soto, Mo. St. _____ 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 <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>May 12, 1874</u>		
7. AGE <u>57</u>	YEARS <u>3</u>	MONTHS <u>11</u>
	DAYS <u>11</u>	If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) St. Paul
 (STATE OR COUNTRY) Mo.

PARENTS	10. NAME OF FATHER <u>Gabriel Blum</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) <u>Bavaria</u> (STATE OR COUNTRY) <u>Germany</u>
	12. MAIDEN NAME OF MOTHER <u>Anistasia Storm</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) <u>Bavaria</u> (STATE OR COUNTRY) <u>Germany</u>

14. INFORMANT Hospital Records
 (Address) Farmington, Mo.

15. FILED 8-24-31 V. J. Robinson
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8-23-31 1931

17. I HEREBY CERTIFY, That I attended deceased from 12-22, 1930 to 8-23, 1931
 that I last saw him alive on 8-23-31, 1931, and that death occurred, on the date stated above, at 1:40 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

General Paralysis of the Insane

83
 (duration) _____ yrs. _____ mos. _____ ds.
 CONTRIBUTORY (SECONDARY) *83*
 (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

B DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS Clinical & Laboratory

(Signed) P. S. Jau, M. D.

8-23-31 (Address) Hosp. #4 Farmington Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSE, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____ DATE OF BURIAL _____

De Soto Mo Aug 26 1931

20. UNDERTAKER _____ ADDRESS _____

Richardson MOTHERSHEAD, De Soto Mo.

SEP 25 1931

