S. No. 2
—1-4-41
-17-39
X26390

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 6 1943

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 21790

Registration District No. 383 | Primary Registration District No. 5655 | Registrar's No. 118

1. PLACE OF DEATH:

(a) County: Bureau
(b) City or town: Mt. Vernon (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Mo State Sanatorium (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 579 days (Specify whether years, months or days)
In this community 579 days

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: St. Charles 22
(c) City or town: St. Charles 3 (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country: /

3. (a) PRINT FULL NAME: Edna L Blase
3. (b) If veteran, name war: No
3. (c) Social Security No.: Unknown
4. Sex: Female
5. Color or race: White
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: August F Blase Jr
6. (c) Age of husband or wife if alive: Unknown years
7. Birth date of deceased: Aug 5 1903 (Month) (Day) (Year)
8. AGE: Years 39 Months 10 Days 17 If less than one day hr. min.
9. Birthplace: Hamburg (City, town, or county) Mo (State or foreign country)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: Wm F Huning
13. Birthplace: New Melle (City, town, or county) Mo (State or foreign country)
MOTHER 14. Maiden name: Susan Berkemeier
15. Birthplace: New Melle (City, town, or county) Mo (State or foreign country)
16. (a) Informant: Mrs Michael Reend Clerk
(b) Address: Mo State Sanatorium
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: June 27 1943 (Month) (Day) (Year)
(c) Place: burial or cremation: St Charles Mo
18. (a) Signature of funeral director: H.D. Fossett
(b) Address: Mt. Vernon, Mo.
19. (a) 6-28-43 (Date received local registrar) (b) Andy Crawford (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 25 year 1943 hour 11:50 minute A M.
21. I hereby certify that I attended the deceased from No 24 1941, to June 25 1943 that I last saw her alive on June 25 1943 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Tuberculosis Meningitis	1 week
Due to:	
Due to:	
Other conditions: Pulmonary tuberculosis (Include pregnancy within 3 months of death)	3 yrs
Major findings: Of operations: Glomerulo Nephritis	
Of autopsy: see above	

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury
23. Signature: [illegible] (M. D. or other)
Address: Mt Vernon Mo. Date signed 6-25-43

1338 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 6,
District File Number 743-825
Date Filed JUL 1 1943

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed Max L. Fossett

Licensed Embalmer No. 4252

P. O. Address Mt. Vernon, M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.