DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 22 1944

Registration District No. 118

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 4188

State File No. 21893

Registrar's No. 1893

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

1. PLACE OF DEATH:
(a) County GASCONADE
(b) City or town OWENSVILLE (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: OWENSVILLE 1 (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ In this community 22 YRS (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County GASCONADE 31 1 6
(c) City or town ____ (If outside city or town limits, write "RURAL")
(d) Street No. ____ (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country ____

3. (a) PRINT FULL NAME FRANK BERNARD BLASKE

3. (b) If veteran, name war L

3. (c) Social Security No. 492-12-7756

4. Sex MALE | 5. Color or race WHITE | 6. (a) Single, widowed, married, divorced 1 MARRIED

6. (b) Name of husband or wife ANNA BLASKE (NEE BURKHOLZ)

6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased SEPT. (Month) 28 (Day) 1879 (Year)

8. AGE: Years 64 | Months 10 | Days 1 | If less than one day ____ hr. ____ min.

9. Birthplace FRIEDRISK TOWN (City, town, or county) MO. 0 (State or foreign country)

10. Usual occupation PAINTER

11. Industry or business ____

FATHER
12. Name CHARLES BLASKE
13. Birthplace L (City, town, or county) GERMANY H (State or foreign country)

MOTHER
14. Maiden name KARSCHNICK
15. Birthplace L (City, town, or county) GERMANY 4 (State or foreign country)

16. (a) Informant VIRGIL BLASKE
(b) Address ST. LOUIS MO

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof AUG 1 1944 (Month) (Day) (Year)
(c) Place: burial or cremation OWENSVILLE CITY CEM.

18. (a) Signature of funeral director Milford W.H. Winter
(b) Address OWENSVILLE MO

19. (a) July 31 1944 (Date received by registrar) Myrtle McWenkel (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 29 year 1944 hour 3:25 minute a. M.

21. I hereby certify that I attended the deceased from Feb. 11, 1944 to July 29, 1944 that I last saw him alive on 7-29, 1944 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Coronary Occlusion	1 HR.
Due to: Hypertension	6 yrs.
Due to: Chronic Myocarditis	6 yrs.
Other conditions (Include pregnancy within 3 months of death): —	
Major findings: Of operations —	
Of autopsy ____	

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 Paul A. Brown M.D. (M. D. or Coroner)
Address Owensville, Mo. Date signed 7-29-44

1944

(Licensed Embalmer's Statement on Reverse Side)

AUG 23 1944

RECEIVED
District Health Officer No. 9,

District File Number.....

Date Filed 8-21-44

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 Me

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

working under my personal supervision.

Signed Milford H. H. Hunter

Licensed Embalmer No. 3838

P. O. Address Owensville Mo

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.

No. 2B
—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 5 upt 97

Registration District No. 118 Primary Registration District No. 4188 Registrar's No.

1. PLACE OF DEATH:
(a) County Gasconade
(b) City or town Owensville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Gasconade
(c) City or town Owensville
(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 Frank B. Blanke
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years

7. Birth date of deceased Sept (Month) 28 (Day) 79 (Year)

8. AGE: Years 64 Months 10 Days If less than one day hr. min.

9. Birthplace (City, town, or county) Mo. (State or foreign country)
10. Usual occupation
11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) July 31 at 1944 (Date received local registrar) (b) Myrtle M. Wenkel (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. Day 29 year 1944 hour [illegible] minute M.
21. I hereby certify that I attended the deceased from , 19 to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

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 (M. D. or other)
Address Date signed

SUPPLEMENTARY

27688