

FILED FEB 3 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 2318

BIRTH NO. _____ REG. DIST. NO. 300 PRIMARY REG. DIST. NO. 3058 Registrar's No. 11

1. PLACE OF DEATH a. COUNTY St Charles		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St Charles	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Charles		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Charles	
c. LENGTH OF STAY (in this place) 66		d. STREET ADDRESS (If rural, give location) 632 Monroe St	
d. FULL NAME OF HOSPITAL OR INSTITUTION 632 Monroe St		d. STREET ADDRESS (If rural, give location) 632 Monroe St	
3. NAME OF DECEASED (Type or Print) a. (First) William		b. (Middle) F	
c. (Last) Bloebaum		4. DATE OF DEATH (Month) (Day) (Year) January 9 1949	
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH January 2 1863
9. AGE (In years last birthday) 86		10. IF UNDER 1 YEAR Months _____ Days _____	
10. IF UNDER 24 HRS. Hours _____ Min. _____		11. BIRTHPLACE (State or foreign country) St Charles Co	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Lawyer		10b. KIND OF BUSINESS OR INDUSTRY Law	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Henry Bloebaum	
13b. MOTHER'S MAIDEN NAME Sophia Schmieger		14. NAME OF HUSBAND OR WIFE Anna Elizabeth Nee Roth	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. None	
17. INFORMANT'S SIGNATURE OR NAME Mrs Florence Bull		ADDRESS 1502 Watson St Charles	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cor-diac decompensation INTERVAL BETWEEN ONSET AND DEATH 4 day ANTECEDENT CAUSES DUE TO (b) Chronic Myocarditis DUE TO (c) Senility II. OTHER SIGNIFICANT CONDITIONS Arteriosclerosis ? ?	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION 11721	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	
21b. PLACE OF INJURY (e.g.: in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? _____		22. I hereby certify that I attended the deceased from Jan 10, 1949 , to Jan 9 , 1949 that I last saw the deceased alive on Jan 9, 1949 , and that death occurred at 7:30 P.M. , from the causes and on the date stated above.	
23a. SIGNATURE [Signature]		23b. ADDRESS [Signature]	
23c. DATE SIGNED 1-11-49		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE Jan 12 1949		24c. NAME OF CEMETERY OR CREMATORY Oak Grove	
24d. LOCATION (City, town, or county) (State) St Charles Mo		DATE REC'D BY LOCAL REG. 1-25-49	
REGISTRAR'S SIGNATURE [Signature]		FUNERAL DIRECTOR'S SIGNATURE [Signature]	
ADDRESS St Charles Mo		ADDRESS St Charles Mo	

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

Date Filed
JAN 31 1949
District Health Officer No. 9
RECEIVED

SEP 1 1953

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed *William C. Lane*

Signed _____
Student Embalmer

Licensed Embalmer No. 3155

P. O. Address St Charles 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.