

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **32753**  
Registrar's No. **8726**

11 OCT 1 1952

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Mo.</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis, Mo.</b>		c. LENGTH OF STAY (In this place)	
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		<b>2289</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Firmin Desloge Hospital</b>		d. STREET ADDRESS (If rural, give location) <b>23 2128 Gravois</b>	
3. NAME OF DECEASED (Type or Print) <b>Frances</b>		a. (First)	b. (Middle)
		c. (Last) <b>Blazek</b>	
4. DATE OF DEATH (Month) (Day) (Year) <b>9-16-52</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>About 1888</b>
9. AGE (In years: last birthday) <b>Abt 64</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Hwk</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and State or Foreign Country) <b>Mo. St. Louis</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Smith, John</b>		13b. MOTHER'S MAIDEN NAME <b>Garden, Mary</b>	
14. NAME OF HUSBAND OR WIFE <b>Joseph Blazek</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME <b>Joseph Blazek</b>		ADDRESS <b>2128 Gravois</b>	
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) <b>Ruptured Esophageal Varices</b>	
		INTERVAL BETWEEN ONSET AND DEATH <b>18 mos.</b>	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Hannec's Cirrhosis</b>	
		DUE TO (c)	
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
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? <b>5811</b>			
22. I hereby certify that I attended the deceased from <b>9-16-52</b> , 19___, to <b>9-16-52</b> , 19___, that I last saw the deceased alive on <b>9-16-52</b> , 19___, and that death occurred at <b>12:40 Pm</b> , from the causes and on the date stated above.			
23a. SIGNATURE <b>W.T. Fitzgerald M.D.</b>		23b. ADDRESS <b>1325 S. Grand, St. Louis 4, Mo.</b>	
23c. DATE SIGNED <b>9-17-52</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>9-19-52</b>	
24c. NAME OF CEMETERY OR CREMATORY <b>New Picker Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis Mo</b>	
DATE REC'D BY LOCAL REG. <b>SEP 18 1952</b>		REGISTRAR'S SIGNATURE <b>Paul Smith M.D.</b>	
25. FUNERAL DIRECTOR'S SIGNATURE <b>Moydell</b>		ADDRESS <b>Funeral Home 1926 Allen</b>	

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

1915

1915

**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

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed Val A. Traumann

Licensed Embalmer No. 4533

P. O. Address J. Traumann

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.