

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

Do not use this space.

29197

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City **St. Louis** (No. **412 & Page Ave.**)

File No.....

Registered No. **8803**

St. Ward)

2. FULL NAME **Louise Blauet Jr**

(a) Residence. No. St. **11** 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

2. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

March 8 1925

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, hrs. or min.

2

6

21

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

at home 1870

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

St. Louis

10. NAME OF FATHER

Louise Blauet

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Mo.

12. MAIDEN NAME OF MOTHER

Ruba Young

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Ill.

14.

INFORMANT (Address)

**Louise Blauet
4106 Page Ave**

15.

FILED **3** 1927

Max B. Stark
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Sept 29 1927**

17. I HEREBY CERTIFY, That I attended deceased from
....., 19....., to
....., 19....., and that
that I last saw h..... alive on....., 19....., and that
death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

**Shock & Injuries (Internal), caused
by being crushed when home collapsed during wind storm Sept. 29th.
at 1:00 P.M.**

CONTRIBUTORY (SECONDARY) ACCIDENT.

18. WHERE WAS DISEASE CONTRACTED?
IF NOT AT PLACE OF DEATH, STATE
8 **DATE OF OPERATION PRECEDES DEATH..... DATE OF.....**

WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed) **P. P. ...**, M. D.

19 (Address) **Carver**

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

St. Peter's Cemetery **10/4/27 19**

20. UNDERTAKER

ADDRESS

Beiderwied **1935**
St. Louis Ave

The name or information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

