LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

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

37950

1. PLACE OF DEATH

County ..... Registration District No. 8[illegible] File No. .....

Township ..... Primary Registration District No. [illegible] Registered No. 11391

City St Louis (No. Deaconess Hospital. St. ..... Ward)

2. FULL NAME Alice Bauer.

(a) Residence. No. 1919 Hickory Str St., 4 Ward. (If nonresident give city or town and State)
(Usual place of abode)

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

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Female.	White.	Married.

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July.31.1867.

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
56.	4.	18.	

8. OCCUPATION OF DECEASED

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

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

(c) Name of employer For Self.

9. BIRTHPLACE (CITY OR TOWN) Grand Tower
(STATE OR COUNTRY) Illinois.

PARENTS

10. NAME OF FATHER Thomas Russell.

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Illinois.

12. MAIDEN NAME OF MOTHER Elizabeth Goodman

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Illinois.

14. INFORMANT Mrs. Claude Browning
(Address) 1919 Hickory Str.

15. FILED DEC 17 1923 19 Max C Starkloff REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 16 1923

17. I HEREBY CERTIFY, That I attended deceased from Nov 20, 1923, to Dec 16, 1923, that I last saw her alive on Dec 15, 1923, and that death occurred, on the date stated above, at 9 45 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis
Chronic Bronchitis
Chronic Interstitial Nephritis

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) ..... (duration) ..... yrs. ..... mos. ..... ds.

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18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) [signature] M. D

Dec 17, 1923 (Address) 636 Metropolitan Bldg

*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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
St Matthews Cemetery.	Dec. 18 1923.

20. UNDERTAKER McLaughlin ADDRESS 1631 Missouri ave

N. B.—Every item of 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.

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1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... No....., ... St. ..... Ward)

2. FULL NAME .....

(a) Residence. No..... St., ... 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

3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

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

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

7. AGE | YEARS | MONTHS | DAYS | If LESS than 1 day, ...hrs. or .....min.

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

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9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

14.
INFORMANT .....
(Address)

15.
FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

17.
I HEREBY CERTIFY, That I attended deceased from .....
....., 19....., to ....., 19.....
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:

.....
.....
.....
.....(duration).....yrs. .....mos. .....ds.

CONTRIBUTORY
(SECONDARY) .....
.....(duration).....yrs. .....mos. .....ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) ....., M. D.
, 19 (Address)

*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. (See reverse side for additional space.)

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