

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

Do not use this space.

9282

1. PLACE OF DEATH

County.....Jackson.....
Township.....Kaw.....
City.....Kansas City..... (No. 5547 Rockhill Road)

Registration District No.....
Primary Registration District No.....
St. Ward)

File No.....
Registered No.....
St. Ward)

2. FULL NAME

George Baer

(a) Residence. No. 5547 Rockhill Road 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. da. How long in U.S., if of foreign birth? 70 yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 20, 1845

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	82	10	10	

8. OCCUPATION OF DECEASED

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

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT J. Baer
(Address) 1108 Ward Platon

15. FILED 3-31-28 M. M. Crowe REGISTRAR
act

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 30 1928

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.....

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis
739013
1911 (duration)..... yrs. mos. da.

CONTRIBUTORY (SECONDARY) arterio-sclerosis
(duration)..... yrs. mos. da.

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) Paul C. Craig, M. D.

3/30, 1928 (Address) Deputy Coroner

*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 Forest Hill DATE OF BURIAL 4/2 1928

20. UNDERTAKER Whitman Sons ADDRESS City

K. 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.

THIS IS A PERMANENT RECORD

CONFIDENTIAL

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