

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

Do not use this space.

1928

1. PLACE OF DEATH

County Marion
Township Mason
City Hannibal

Registration District No. 547
Primary Registration District No. 3029
(No. 181A Valley St.)

File No. 14059
Registered No. 874 (Ward)

2. FULL NAME

James Bauer

(a) Residence. No. 1815 Valley St., 4 Ward.

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 20-1856

7. AGE: YEARS 72 MONTHS 1 DAYS 10 If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer) " "
(c) Name of employer " "

9. BIRTHPLACE (CITY OR TOWN) St. Louis, Mo.
(STATE OR COUNTRY)

10. NAME OF FATHER Don't know

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 John P. Bauer
(Address) Hannibal Mo.

15. FILED 4/4/28 19. 6/6 Trade REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 5- 1928

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at 7:50: a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Bright's disease
(Kidney disease)
less Heart disease
2 H (duration) 1 yrs. 7 mos. 7 ds.

CONTRIBUTORY (SECONDARY) The 2 diseases above
mutually caused (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED? at place of death
IF NOT AT PLACE OF DEATH, _____
DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Heart and mitric
Oscil urine test
(Signed) Francis M. Moore, M. D.
, 19 3/9/28 (Address) 6th st

*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 Mt. Olivet Cemetery DATE OF BURIAL 4/7 19 28

20. UNDERTAKER Delwary Funeral Home ADDRESS Hannibal Mo.

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.

RECORD WITH CHANGING INITIALS IS A PERMANENT RECORD

JUN 7

