

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

Do not use this space.

20327

**1. PLACE OF DEATH**

County..... Registration District No. **791**  
 Township..... Primary Registration District No. **1003**  
 City..... (No. *City Infirmary*) St. .... (Ward)

File No. ....  
 Registered No. **6017**

**2. FULL NAME**

(a) Residence. No. *John Bauer* City *Infirmary* St. *13* 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 <i>Male</i> <i>White</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <i>single</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <i>Mar 3 1887</i>		
7. AGE <i>73</i>	YEARS <i>2</i>	MONTHS <i>2</i>
	DAYS <i>2</i>	IF LESS than 1 day, ..... hrs. or ..... min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work..... <i>Ration</i> (b) General nature of industry, business, or establishment in which employed (or employer)..... (c) Name of employer.....		

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *May 30 - 19 29*  
 17. I HEREBY CERTIFY, That I attended deceased from *May 23 19 29*, 19 *28* to *May 30 - 19 29*, that I last saw him alive on *May 30 - 19 29*, and that death occurred, on the date stated above, at *3:30 A.M.*

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

*Ch. Myocarditis with Decompensation*  
*34*  
*930* (duration) *1* yrs. *7* mos. *7* ds.  
 CONTRIBUTORY (SECONDARY) *Syphilis*  
 (duration) *25* yrs. .... mos. .... ds.

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH *708 So. Broadway*  
 DID AN OPERATION PRECEDE DEATH? *no* DATE OF *✓*  
 WAS THERE AN AUTOPSY? *no*  
 WHAT TEST CONFIRMED DIAGNOSIS? *none*

(Signed) *Ben Margulies* M. D.  
 (Address) *5600 Arsenal 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 *St. Louis* DATE OF BURIAL *6/1 29*

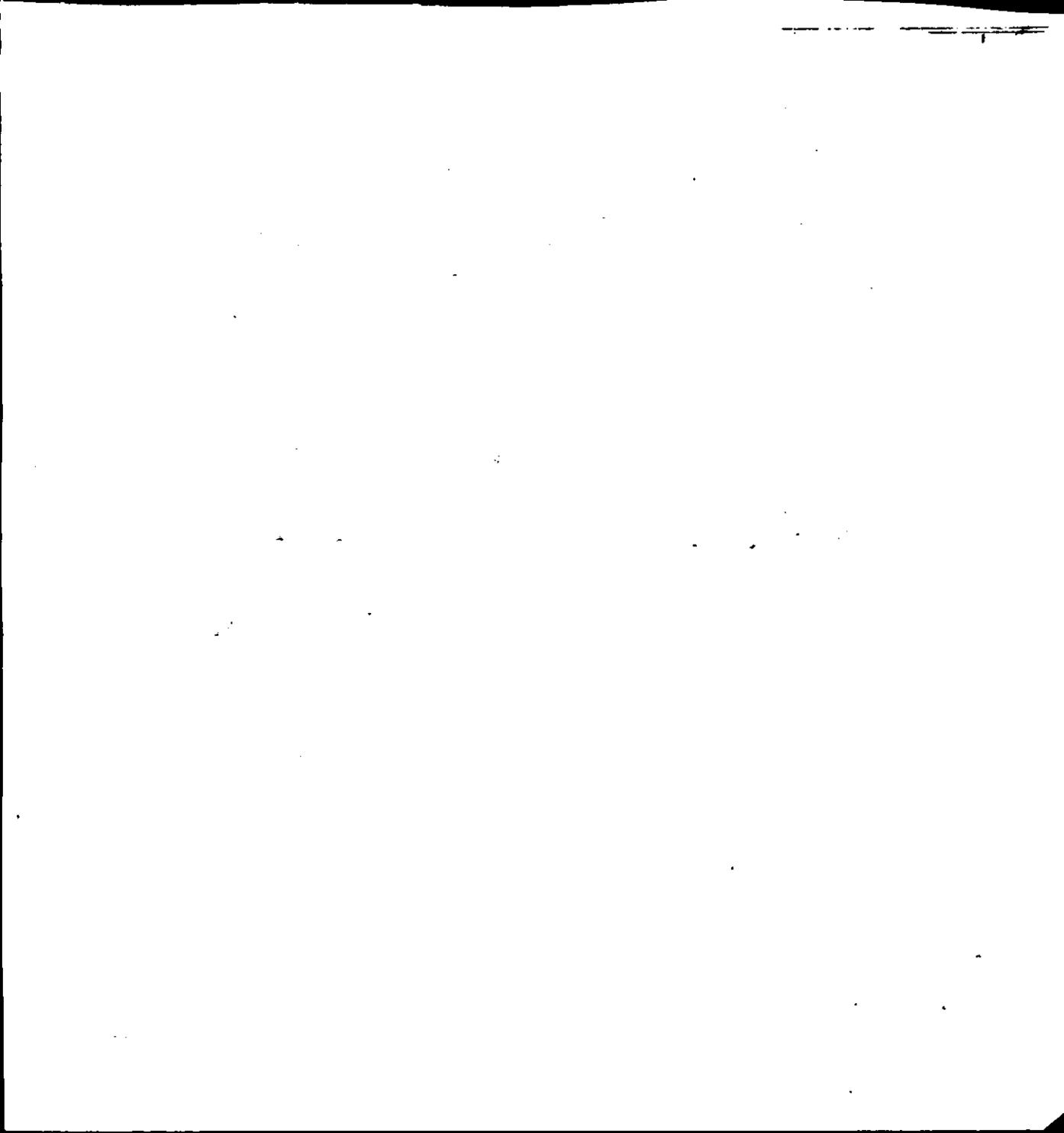
20. UNDERTAKER *W. Richter* ADDRESS *3800 Rte 29*

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

PARENTS	10. NAME OF FATHER <i>Michael Bauer</i>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN)..... <i>Germany</i> (STATE OR COUNTRY)
	12. MAIDEN NAME OF MOTHER <i>Sara Maria Kraft</i>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN)..... <i>Germany</i> (STATE OR COUNTRY)

14. INFORMANT *M. C. ...*  
 (Address) *5800 Arsenal St*

15. FILED *JUN - 1 1929* REGISTRAR



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

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County..... Registration District No. 791  
 Township..... Primary Registration District No. 1003  
 City St. Louis (No. ....) St. .... Ward)

File No. ....

Registered No. 6017

**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.

*John Basler*

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) S

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar 3 - 1855

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
73 2 27

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work..... (duration) ..... yrs. .... mos. .... ds.  
 (b) General nature of industry, business, or establishment in which employed (or employer)..... (duration) ..... yrs. .... mos. .... ds.  
 (c) Name of employer.....

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

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 7 May 19 19 19  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

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THE CAUSE OF DEATH\* WAS AS FOLLOWS:

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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL..... DATE OF BURIAL..... 19.....

20. UNDERTAKER..... ADDRESS.....

SUPPLEMENTARY

FEE FOR CERTIFICATE UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

1929  
# 20327