

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

Do not use this space.

42833

1. PLACE OF DEATH
 100 County Scott Registration District No. F 20 File No. _____
 Township Sylvania Primary Registration District No. 6067 F 96 Registered No. _____
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME Barney Baudendistel
 (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 <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Celestine Baudendistel</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>5/6/1922</u>		
7. AGE <u>60</u>	YEARS <u>7</u>	MONTHS <u>24</u>
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Farmen</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____ (c) Name of employer _____		If LESS than 1 day, _____ hrs. or _____ min.
9. BIRTHPLACE (CITY OR TOWN) <u>Mo</u> (STATE OR COUNTRY)		
10. NAME OF FATHER <u>Nicholas Baudendistel</u>		
11. BIRTHPLACE OF FATHER (CITY OR TOWN) <u>Ger. 10</u> (STATE OR COUNTRY)		
12. MAIDEN NAME OF MOTHER <u>Helen Keifer</u>		
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) <u>Ger.</u> (STATE OR COUNTRY)		
14. INFORMANT <u>Celestine Baudendistel</u> (Address) <u>Craw Mo</u>		
15. FILED <u>1-9-53</u> <u>G. L. Schuman</u> REGISTRAR		

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12/30 1932

17. I HEREBY CERTIFY, That I attended deceased from 12/24, 1932 to 12/29, 1932, that I last saw him alive on 12/28, 1932, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Hemorrhage
8-7-7
 (duration) _____ yrs. _____ mos. 5 ds.

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

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH _____ 1

19. DID AN OPERATION PRECEDE DEATH? No DATE OF _____

20. WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) J. A. Clume, M. D.
 (Address) Craw Mo

*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 New Hamburg Mo DATE OF BURIAL 1/6 1933

20. UNDERTAKER T. J. Heim Co ADDRESS Craw

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

