

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

Do not use this space.

JUN 28 1937

21184

1. PLACE OF DEATH

County St. Clair
Township Center
City (No. _____) _____

Registration District No. 764
Primary Registration District No. 6007

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Sara Magdalena Bayer

(a) Residence, No. _____ St. _____ Ward _____
(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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 2-18-1934

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
2 11 1

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Orcutt Mo

MOTHER FATHER 13. NAME H. C. Bayer

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Clair Co Mo

15. MAIDEN NAME Myrtle Richardson

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Roscoe Mo

17. INFORMANT (ADDRESS) H. C. Bayer Orcutt Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Kills Chapel DATE January 24 1937

19. UNDERTAKER (ADDRESS) F. B. ...

20. FILED 1-20 1937 Jos. R. Carter Deputy Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-19 1937

22. I HEREBY CERTIFY, That I attended deceased from Jan 16 1937, to Jan 19 1937. I last saw him alive on Jan 19 1937. Death is said to have occurred on the date stated above, at 12 P.M. The principal cause of death and related causes of importance were as follows:

Tuber. Pneumonia
Date of onset _____
Other contributory causes of importance: _____

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
(Signed) E. S. Stratten, M. D.
(Address) Spring City

CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state EXACTLY what they saw. DO NOT SIGN unless you are a PHYSICIAN. DO NOT SIGN unless you are a PHYSICIAN. DO NOT SIGN unless you are a PHYSICIAN.



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