

REC'D APR 21 1939

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

Dr. P. Lanning
12189
Do not use this space.

1. PLACE OF DEATH ²
(a) County *St. Genevieve* Registration District No. *780*
(b) Township *St. Gen* Primary Registration District No. *6025*
(c) City (d) Street No. St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME *EMILY BAUMAN*
(a) Residence, No. St. (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *FEMALE* 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 *ANDREW BAUMAN*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *JAN. 6 1878*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
60 9 5

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *HOUSE WIFE*
9. Industry or business in which work was done, as 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) *ORORA*
(STATE OR COUNTRY) *MISSOURI*

FATHER 13. NAME *XAVIER LIPP*

14. BIRTHPLACE (CITY OR TOWN) *GERMANY*
(STATE OR COUNTRY) *1*

MOTHER 15. MAIDEN NAME *CATHRINE DALLAS*

16. BIRTHPLACE (CITY OR TOWN) *NEW ORLEANS*
(STATE OR COUNTRY) *LOUISIANA*

17. INFORMANT *Andrew B. Bauman*
(ADDRESS) *St. Genevieve Mo.*

18. BURIAL, CREMATION, OR REMOVAL PLACE *St. Genevieve Mo.* DATE *3/14* '39

19. FUNERAL DIRECTOR (NAME) *St. C. Baker*
(ADDRESS) *St. Genevieve Mo.*

20. FILED *Mar. 13* 1939 *T. W. Douglas*
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *March 11* 1939

22. I HEREBY CERTIFY, That I attended deceased from *Nov. 14* 1928, to *March 11* 1939
I last saw h. e. r. alive on *March 11* 1939. Death is said to have occurred on the date stated above, at *MISSP.*
The principal cause of death and related causes of importance were as follows:

Chronic Valvular Heart Disease
92
Other contributory causes of importance:
Broncho pneumonia
Date of onset ?
3/8/39

Name of operation *None* Date of
What test confirmed diagnosis? *Clinical* Was there an autopsy? *No*

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury 19

Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? *No*
If so, specify
(Signed) *P. Lanning*, M. D.
701 (Address) *St. Genevieve 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.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

Leo C. Basler

....., or by

Registered Apprentice No....., working under my personal supervision.

Signed.....

Leo C. Basler

Licensed Embalmer No.....

1985

P. O. Address.....

St. Genevieve Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.