

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.

250

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

21411  
 Do not use this space.

DECD JUL 13 1939

1. PLACE OF DEATH

(a) County Andrew Registration District No. 13

(b) Township \_\_\_\_\_ Primary Registration District No. 4010 Registered No. 38

(c) City Savannah (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 Jacob Baum

(a) Residence, No. Savannah Mo. St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Male 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 Elizabeth Baum

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept. 5 1847.

7. AGE YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
91	9	10	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired Farmer

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) Andrew County 0  
 (STATE OR COUNTRY) Missouri 6

FATHER

13. NAME John Baum 6

14. BIRTHPLACE (CITY OR TOWN) Bin Jhem 6  
 (STATE OR COUNTRY) Germany

MOTHER

15. MAIDEN NAME Christina Frick

16. BIRTHPLACE (CITY OR TOWN) Bin Jhem  
 (STATE OR COUNTRY) Germany

17. INFORMANT Chester Baum  
 (ADDRESS) Bolckow Missouri

18. BURIAL, CREMATION, OR REMOVAL PLACE Savannah Mo. DATE June 17 1939

19. FUNERAL DIRECTOR (NAME) E. C. Breit  
 (ADDRESS) Savannah Missouri

20. FILED June 17, 1939 Mrs. Jennie Rash  
 Local Registrar. 934

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 15, 1939

22. I HEREBY CERTIFY That I attended deceased from Aug 28, 1938, to June 15, 1939  
 I last saw him alive on June 15, 1939. Death is said to have occurred on the date stated above, at 4:30 p. m.  
 The principal cause of death and related causes of importance were as follows:  
Hypertension.  
Angina Pectoris

Date of onset Years 8-28-38

Other contributory causes of importance: 94a

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? Physical 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\_\_\_\_  
 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) W. P. Kelley M. D. M. D. Savannah Mo.

RECEIVED

District Health Officer No. 111

District File Number 739-841

Date Filed JUL 12 1939

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**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, \_\_\_\_\_

E. C. Breit, or by \_\_\_\_\_

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

Signed E. C. Breit

Licensed Embalmer No. 2650

P. O. Address Savannah 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.**