

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

32375
Do not use this space.

1. PLACE OF DEATH **DEPT OCT 10 1939**

(a) County **Gasconade** Registration District No. **303**
 (b) Township **HOARK** Primary Registration District No. **5420**
 (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 **2** yrs. mos. da. (f) How long in U.S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME **KATHERINA MARIE BAIER**

(a) Residence, No. **Gasconade County** 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 **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED **Married**

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Nov. 1, 1872**

7. AGE YEARS **67** MONTHS **10** DAYS **14** If LESS than 1 day, _____ hrs. or _____ min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **Housewife**

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) **Sept. 14, 1937** 11. Total time (years) spent in this occupation **40**

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Big Berger, Mo.**

FATHER 13. NAME **Writz Oberg** 0
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Germany** 6

MOTHER 15. MAIDEN NAME **Carolina Schleiber** 6
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Germany**

17. INFORMANT **Henry Blom**
 (ADDRESS) **Hermann, Mo.**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Union Zion Evang. Cemetery** DATE **Sept. 17, 1939**

19. FUNERAL DIRECTOR (NAME) **Hugo Blumer**
 (ADDRESS) **Hermann, Mo.**

20. FILED **9-17** 19**39** **Anna K. Riekhoff** 274 (Address) **Bermann Mo**
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **9-14-1939**

22. I HEREBY CERTIFY, that I attended deceased from **Jan 1 - 1939**, to **Sept 14 - 1939**
 Last saw her alive on **Sept 13 - 1939**. Death is said to have occurred on the date stated above, at **3:00** p.m.
 The principal cause of death and related causes of importance were as follows:
Mitral Insufficiency Date of onset **1911**
 Other contributory causes of importance: **Nephritis Chronic**

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ 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) **Howard Korkman**, M. D.
 (Address) **Bermann Mo**

with information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state USE 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, or by.....

..... Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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

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

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