

WHILE I LIVE—USE UNFADING BLACK INK—MAKE 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
NOV 13 1939

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **37913**
9752
Registrar's No.

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:
(a) County 1
(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Jewish Hospital.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 months.
(Specify whether years, months or days)
In this community 11 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 1
(c) City or town St. Louis. 12
(If outside city or town limits, write "RURAL")
(d) Street No. 4950 McPherson.
(If rural, give location)
(e) If foreign born, how long in U. S. A. — years.

3. (a) PRINT FULL NAME Albert E. Baer (60)
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month NOV. day 14
year 1939 hour 10 minute 10 A. M.
21. I hereby certify that I attended the deceased from 8-4-39
_____, 19____, to 11-14, 1939.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

that I last saw him alive on NOV. 14, 1939, and that death occurred on the date and hour stated above.

6. (b) Name of husband or wife Tillie Baer 6. (c) Age of husband or wife if alive 65 years
7. Birth date of deceased Nov. 24, 1864
(Month) (Day) (Year)

Immediate cause of death
Carcinoma of Urinary Bladder - 7 mos.
Benign Hypertrophy of Prostate. - 7 mos.

8. AGE: Years 74 Months 11 Days 20 If less than one day _____ hr. _____ min.

Due to 51
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

9. Birthplace Mississippi
(City, town, or county) (State or foreign country)
10. Usual occupation Clothing Salesman

PHYSICIAN
Major findings:
Of operations Enlarged Prostate.
Papilloma of Bladder.
Of autopsy not done.
Underline the cause to which death should be charged statistically.

11. Industry or business retired
12. Name Jacob Baer
13. Birthplace Germany
(State or foreign country)
14. Maiden name Clara Strauss
15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Tillie Baer
(b) Address 4950 McPherson
17. (a) Burial (b) Date thereof 11-15-39
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Mount Sinai Cem.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) na.
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? — (Specify type of place) (e) Means of injury _____

18. (a) Signature of funeral director Herman Rindskopf
5216 Delmar Blvd.
(b) Address
19. (a) NOV 15 1939 (b) J. F. Budzisk
(Date received local registrar) (Registrar's signature)

23. Signature John Schneider (M. D. or other)
Address Jewish Hospital - St. Louis Date signed 11/15/39

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.....

Paul W. Cooper

Licensed Embalmer No. 3830

P. O. Address 5216 Selma

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.