

JAN 12 1940
Registration District No. _____

Primary Registration District No. _____

1. PLACE OF DEATH: **2**
(a) County **1000**
(b) City or town **ST. LOUIS**
(c) Name of hospital or institution: **416 FILLMORE ST.**
(d) Length of stay: In hospital or institution _____
In this community _____
years, months or days

3. (a) PRINT FULL NAME **MARY BAYER**
3. (b) If veteran, name war **none**
3. (c) Social Security No. **none**

4. Sex **FEMALE** 5. Color or race **WHITE**
6. (a) **Single**, widowed, married, divorced
6. (b) Name of husband or wife **SIMON BAYER**
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Nov. 18 1857**
(Month) (Day) (Year)

8. AGE: Years **82** Months **0** Days **12**
If less than one day _____ hr. _____ min.

9. Birthplace **MISSOURI**
(City, town, or county) (State or foreign country)

10. Usual occupation **HOUSEWIFE**

11. Industry or business _____
12. Name **PETER KIRCHNER**
13. Birthplace **MISSOURI**
(City, town, or county) (State or foreign country)
14. Maiden name **ANASTASIA SCHWEIS**
15. Birthplace **GERMANY**
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Veronia Werner**
(b) Address **416 Fillmore**

17. (a) **BURIAL** (b) Date thereof **12/3/39**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Bloomdale Ma**

18. (a) Signature of funeral director **J. P. Fessler**
(b) Address **7128 Michigan a.**

19. **DEC 1 1939** (b) **J. B. Brubaker**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: **1**
(a) State **MO** (b) County _____
(c) City or town **ST LOUIS**
(d) Street No. **416 FILLMORE ST.**
(e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Nov** day **30**
year **1939** hour **5 A M** minute _____ M.
21. I hereby certify that I attended the deceased from **Nov. 21 1939** to **Nov 30 1939**
that I last saw **her** alive on **Nov. 29 1939**
and that death occurred on the date and hour stated above.

Immediate cause of death, **Chronic myocarditis**
Due to _____
Due to _____
Other conditions **Arteriosclerosis**
(Include pregnancy within 3 months of death) **Arone**
Major findings: _____
Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(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 _____
23. Signature **J. P. Fessler** (M. D. or other) **W. H. ...**
Address **7702 ...** Date signed **12/1/39**

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, or by.....

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

working under my personal supervision.

Signed Harry J. Schumacher

Licensed Embalmer No. 2679

P. O. Address 732 Remay

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.