

791  
1000

Primary Registration District No. \_\_\_\_\_

Registrar's No. **663**

1. PLACE OF DEATH: **1000**  
(a) County \_\_\_\_\_  
(b) City or town **St. Louis**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**2835a Cherokee St.**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community **Life**  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Missouri** (b) County \_\_\_\_\_  
(c) City or town **St. Louis** **24**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **2835a Cherokee St.**  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME **Simon Baur**  
3. (b) If veteran, name war **---**  
3. (c) Social Security No. **----**

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **Jan.** day **23**  
year **1940** hour **5** minute **45 a.m.**

4. Sex **Male** 5. Color or race **White**  
6. (a) Single, widowed, married, divorced **Married**  
6. (b) Name of husband or wife **Gertrude M. Baur**  
6. (c) Age of husband or wife if alive **59** years  
7. Birth date of deceased **March 26, 1870**  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **1-27-**, 19**40** to **1-23-**, 19**40**  
that I last saw him alive on **1-23-40**, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<b>69</b>	<b>9</b>	<b>28</b>	hr. _____ min.

Immediate cause of death  
**Chronic Myocarditis**  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

9. Birthplace **St. Louis Missouri**  
(City, town, or county) (State or foreign country)  
10. Usual occupation **Moving Business**

Other conditions **Paralysis Acute**  
(Include pregnancy within months of death) **Diabetes Mellitus**  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

MOTHER FATHER  
11. Industry or business \_\_\_\_\_  
12. Name **Solomon Baur**  
13. Birthplace **Germany**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Elizabeth Schroeder**  
(City, town, county) (State or foreign country)  
15. Birthplace **Germany**  
(City, town, county) (State or foreign country)

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) **NO**  
(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)  
(Means of injury)

16. (a) Informant's own signature **Gertrude M. Baur**  
(b) Address **2835a Cherokee St.**  
17. (a) **Burial** (b) Date thereof **1/25/40**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Sunset Burial Park**  
18. (a) Signature of funeral director **Wacker-Helderte**  
(b) Address **2331 S. Broadway**  
19. (a) **JAN 23 1940** (b) \_\_\_\_\_  
(Date received local registrar)

23. Signature **Joseph E. Carney** (M. D.)  
Address **5215 Trisco Bldg** Date signed **1-23-40**

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.

1 X1951

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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, or by.....

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

working under my personal supervision.

Signed.....

*Frank J. Dyland Sr.*

Licensed Embalmer No. ....

*2645*

P. O. Address.....

*St Louis 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.**