

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

33597

State File No. 8294

NOV 16 1940 791

Primary Registration District No. 1003

Registrar's No.

1. PLACE OF DEATH:

(a) County.....
(b) City or town St. Louis
(c) Name of hospital or institution: Missouri Baptist Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10 days
(Specify whether
In this community. 3 weeks
years, months or days)

3. (a) PRINT FULL NAME Barbara Bauer

3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife Anton 6. (c) Age of husband or wife if alive 73 years

7. Birth date of deceased October 8, 1879
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
60 11 25 hr. min.

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

10. Usual occupation Housewife

11. Industry or business

12. Name Frank Schwartz

13. Birthplace Austria
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Austria
(City, town, or county) (State or foreign country)

16. (a) Informant Robert Bauer

(b) Address 2900a Eads Ave

17. (a) Burial (b) Date thereof 10/7/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New S.S. Peter & Paul Cem

18. (a) Signature of funeral director A. W. McLaughlin

(b) Address 2301 Lafayette Ave

19. (a) OCT 5 1940 (b) J. J. Fredrick
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County.....
(c) City or town Doniphan
(If outside city or town limits, write "RURAL")
(d) Street No.....
(If rural, give location)
(e) If foreign born, how long in U. S. A.?..... years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 3
year 1940 hour 7 minute 30 P.M.

21. I hereby certify that I attended the deceased from September 24, 1940, to October 3, 1940;
that I last saw h..... alive on....., 19.....;
and that death occurred on the date and hour stated above.

Immediate cause of death.....

Carcinoma of Liver Duration 2 mo

Due to.....

Due to.....

Other conditions (Include pregnancy within 3 months of death) H/O

Major findings: Of operations Cholecystectomy

Of autopsy Refused

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?.....
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? P. S. Taylor (Specify type of place) (e) Means of injury !

23. Signature P. S. Taylor (M. D. or other) !
Address Box 40, Taylor Date signed 10/14/40

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

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 A. Keith

Licensed Embalmer No. 3612

P. O. Address

2317 Lafayette

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

If this body is not embalmed, fact should be so stated above.