

11-10-39
5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

FILED NOV 25 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

36405

Registration District No. 784

Primary Registration District No. 177

State File No. _____

Registrar's No. 2016

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Richmonds Heights
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Marys Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Seventeen days
(Specify whether
In this community about 60 years
years, months or days)

8. (a) PRINT
FULL NAME Norbert W. Baier

8. (b) If veteran, name war none 8. (c) Social Security No. 489-14-0602

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

6. (b) Name of husband or wife Mary White 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Dont Know
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
about 65 hr. min.

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

10. Usual occupation Floor Walker

11. Industry or business Department Store

12. Name Joseph Baier

18. Birthplace Dont Know Austria
(City, town, or county) (State or foreign country)

14. Maiden name Genevieve Baier

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

16. (a) Informant Mary J Baier
(b) Address 3547 Halliday Avenue.

17. (a) Burial (b) Date thereof 10/26/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director J. Thomas J. J...
(b) Address 1519 South Grand Blvd.

19. (a) OCT 24 1940 (b) L.R. M...
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 3547 Halliday Avenue
(If rural, give location)
(e) If foreign born, how long in U. S. A. About 60 years years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 24
year 1940 hour 6:10 minute A.M.

21. I hereby certify that I attended the deceased from Oct 6 1940 to Oct 24 1940
that I last saw him alive on Oct 23 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia

Due to Staphylococcus

Due to Staphylococcus Septicaemia

Other conditions Following operation
(Include pregnancy within 3 months of death)

Major findings: Direct Inguinal
Of operations hernial

Of autopsy See 1220

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? _____ (Specify type of place)
(e) Means of injury _____

23. Signature [Signature] (M. D. or other) 10/24/40
Address Summit Dist Bld Date signed 10/24/40

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.....

John D. Letter

Licensed Embalmer No. *3880*

P. O. Address.....

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.