No. 2
1-13-40
-17-39
I X23159

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 37823

Registration District No. 399 — Primary Registration District No. 1002 — Registrar's No. 4421

FILED DEC 11 1940

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City, (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Joseph Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 week (Specify whether years, months or days) 1
In this community 15 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson
(c) City or town Kansas City, (If outside city or town limits, write "RURAL")
(d) Street No. 2840 Forest (If rural, give location) 0
(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME Milton J. Bauer
3. (b) If veteran, name war none
3. (c) Social Security No. 486-07-3389
4. Sex Male
5. Color or race white
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Josephine Bauer
6. (c) Age of husband or wife if alive 57 years
7. Birth date of deceased Oct. (Month) 27 (Day) 1878 (Year)

8. AGE: Years 62 | Months 0 | Days 23 | If less than one day ____ hr. ____ min.

9. Birthplace Missouri (City, town, or county) 0 (State or foreign country)
10. Usual occupation Newspaper man 6
11. Industry or business 1
MOTHER FATHER
12. Name John Bauer
13. Birthplace (City, town, or county) Germany (State or foreign country)
14. Maiden name Elizabeth Krumme
15. Birthplace Maryland (City, town, or county) (State or foreign country)
16. (a) Informant Mrs. Josephine Bauer
(b) Address 2840 Forest
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-22-40 (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Mora, St. Joseph. Mo.
18. (a) Signature of funeral director Freeman Mortuary
(b) Address 104 West 42nd Street
19. (a) 11-20,40 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 20 year 1940 hour 3:00 minute A.M.
21. I hereby certify that I attended the deceased from 6-26-40, 1940, to 11-19, 1940; that I last saw him alive on 11-19, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death — Duration
Carcinoma of Sigmoid Colon 5 yrs.
+ Cirrhosis of Liver.
Due to
46
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy C.A. of Sigmoid + Hobnail liver

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? (Specify type of place) (e) Means of injury 1

23. Signature L. W. Brumm (M. D. or other)
Address 3200 Indiana Ave. Date signed 11-20-40

(Licensed Embalmer's Statement on Reverse Side)

in after 1:00
3200 Indefinite

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 Clarence W Chiles

Licensed Embalmer No. 3473

P. O. Address Mc C Mo

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

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