

APR 23 1943 318

Registration District No. _____ Primary Registration District No. **1003** Registrar's No. **3529**

1. PLACE OF DEATH:

(a) County _____
 (b) City or town **St. Louis, Mo.**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
BARNES HOSPITAL
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **7 days** (Specify whether
 In this community **About 36 years** (Specify whether
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County _____
 (c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
 (d) Street No. **5370 Pershing Ave**
(If rural, give location)
 (e) Citizen of foreign country? **NO** (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **Nat K. Baum**

3. (b) If veteran, name war **none** 3. (c) Social Security No. **493-09-0973**

4. Sex **male** 5. Color or Race **W.** 6. (a) Single, widowed, married, divorced **single**

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

7. Birth date of deceased **July 10, 1878**
(Month) (Day) (Year)

8. AGE: Years **64** Months **9** Days **4** If less than one day _____ hr. _____ min.

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

10. Usual occupation **Mfg.**

11. Industry or business **mens neckwear**

12. Name **Samuel K. Baum**

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

14. Maiden name **Sarah Marcus**

15. Birthplace **Cincinnati Ohio**
(City, town, or county) (State or foreign country)

16. (a) Informant **Joseph Baum**

(b) Address **Horonado Hotel**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **4/16/43**
(Month) (Day) (Year)

(c) Place: burial or cremation **Cincinnati Ohio**

18. (a) Signature of funeral director **Mayer**

(b) Address **4356 Lindell Blvd**

19. (a) **APR 15 1943** (Date received local registrar) (b) **J. F. Beede** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **14** year **1943** hour **4** minute **05 A.M.**

21. I hereby certify that I attended the deceased from **April 7**, 1943, to **April 14**, 1943 that I last saw him alive on **April 14**, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death **Bronchiogenic carcinoma - post-operative**

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **Bronchiogenic Ca of lung**
 Of autopsy _____

Duration

?

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 _____

Signature **M. G. Abney** (M. D. or other)

Address **BARNES HOSPITAL** Date signed **4/16/43**

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.....

G. Wilkinson

Licensed Embalmer No.....

3575

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, fact should be so stated above.