

ED SEP 8 1943
Registration District No. 24

Primary Registration District No. 3046

Registrar's No. 116

1. PLACE OF DEATH:

(a) County Monteau
(b) City or town California
(c) Name of hospital or institution Lathrop Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 1/2 hrs
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Cooper
(c) City or town Prairie Home
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country GERMANY

3. (a) PRINT FULL NAME JOHN P. BAER

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex male 5. Color of hair white 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 12 29 1868
(Month) (Day) (Year)

8. AGE: Years 74 Months 8 Days 1 If less than one day _____ hr. _____ min.

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

10. Usual occupation Carpenter

11. Industry or business _____

MOTHER FATHER { 12. Name NICOLAUS BAER
13. Birthplace GERMANY
(City, town, or county) (State or foreign country)
14. Maiden name SOPHIA DECEL
15. Birthplace GERMANY
(City, town, or county) (State or foreign country)

16. (a) Informant Marie Fries
(b) Address California Mo
17. (a) Burial (b) Date thereof 9-1-43
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Monteau Ex. Cem.
18. (a) Signature of funeral director C. J. Hornbeck
(b) Address Prairie Home Mo
19. (a) Aug 31 1943 (b) A. J. Allen
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 30
year 1943 hour 11 minute 40 P.M.
21. I hereby certify that I attended the deceased from Aug 30 to 1943
that I last saw him live on Aug 30 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage
Duration _____

Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____
Of autopsy _____
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 _____
23. Signature A. K. Muntz (M. D. or other) MD
Address Prairie Home Mo Date signed 8-31-43

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

DEC 3 1943

[Faint handwritten marks]

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 *C. Albert Hornbeck*

Licensed Embalmer No. *2714*

P. O. Address *Prairie Home 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, fact should be so stated above.