

X35897

Registration District No. 343

Primary Registration District No. 4506

Registrar's No. _____

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

1. PLACE OF DEATH

(a) County Stoddard

(b) City or town Essex
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

In this community _____
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Rose Pearl Bage

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Oct 26 1877
(Month) (Day) (Year)

8. AGE: Years 66 Months 1 Days 8 If less than one day _____ hr. _____ min.

9. Birthplace Jefferson Co. Hillsboro Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Housekeeper

11. Industry or business London Strickland

MOTHER FATHER

12. Name Jefferson Co. Mo

13. Birthplace Jefferson Co. Mo
(City, town, or county) (State or foreign country)

14. Maiden name Martha Bauerlich

15. Birthplace Jefferson Co. Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Thelma Dale Day

(b) Address Essex Mo

17. (a) Removal (b) Date thereof 12-6-1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park, St. Louis

18. (a) Signature of funeral director Waters Funeral

(b) Address Dexter Mo

19. (a) Dec 16-43 (b) Nora Gross
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Stoddard Mo

(c) City or town Essex
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 4
year 1943 hour 6 minute P.M.

21. I hereby certify that I attended the deceased from Nov 26
_____, 19____, to 1943 19____
that I last saw him or her alive on Dec 4 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to _____

Due to _____

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

PHYSICIAN

Major findings: _____

Of operations _____

Of autopsy _____

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 [Signature] (M.D. or other) _____
Address Essex Mo Date signed 12/18/43

RECEIVED

District Health Office No. 2,

District File Number 1243-1571

Date Filed 12-20-43

MAR 16 1944

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.....

Licensed Embalmer No.....

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.