

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 862

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

1. PLACE OF DEATH:

(a) County.....

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

(c) Name of hospital or institution:
721 Pestalozzi
(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) 60 yrs.

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. 3719a South Jefferson
(If rural, give location)

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

3. (a) PRINT FULL NAME Bayer, Alfred H.

3. (b) If veteran, name war.....

3. (c) Social Security No. 494-01-5854

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife..... Eliz. Sophie Handel

6. (c) Age of husband or wife if alive 58 years

7. Birth date of deceased July 7 1883
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

60 6 19 hr. min.

9. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Beer bottler

11. Industry or business Brewery

MOTHER FATHER { 12. Name John Bayer

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

14. Maiden name Margaretta Schmidt

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

16. (a) Informant Widow and daughter

(b) Address 3719a So. Jefferson

17. (a) Burial (b) Date thereof Jan. 29, 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New St. Marcus Cemetery Beiderwieden F.H., Inc.

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

(b) Address 1936 St. Louis Ave.

19. (a) JAN 28 1944 (Date received local registrar)
J. P. Bueck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 26
year 1944 hour 10 minute 25 P.M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....
that I last saw h..... alive on....., 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death.....
Chronic aortic and
occlusion of lumen of
right coronary
Due to.....

Chronic aortic
non-syphilitic
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?
(Specify type of place)

While at work..... (e) Means of injury.....

23. Signature Alfred Perry (M. D. or other)
Alfred Perry Address..... Date signed 1/28/44

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..... *Delbert J. Krueger*
Licensed Embalmer No..... *3497*
P. O. Address..... *1936 St. Louis*

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 862

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: _____
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(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 _____

3. (a) PRINT FULL NAME ALFRED H. BAYER

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

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

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

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year) _____

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

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____
15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant Cliff. Bayer

(b) Address 37109 1/2 S. Jefferson

17. (a) _____ (b) Date _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 2-7-44 (b) J.F. Bealack
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 26
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

MOTHER FATHER

SUPPLEMENTARY

51

JUN 22 1944

JUN 21 1944