

V. S. No. 2
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Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **31270**
Registrar's No. **36**

FILED OCT 11 1944

Registration District No. **3039-5689**
Primary Registration District No. **3039-5689**

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

1. PLACE OF DEATH:
(a) County Linn
(b) City or town Rural MAACONIAL OH
(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 1
In this community 90 years
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Linn 51
(c) City or town Rural
(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 JOHN BAER
(b) If veteran, name war _____ (c) Social Security No. none

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Sept day 4
year 1944 hour 8 minute 30 P M.
21. I hereby certify that I attended the deceased from 8/21, 1944, to 9/4, 1944.
that I last saw him alive on 5/20, 1944
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Aug 28 - 1854
(Month) (Day) (Year)

Immediate cause of death
Acute Myocarditis
Diabetes Mellitus
Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

8. AGE: Years Months Days If less than one day
90 0 7 _____ hr. _____ min.

Major findings:
Of operations _____
Of autopsy _____
PHYSICIAN
Underline the cause to which death should be charged statistically.

9. Birthplace Penn.
(City, town, or county) (State or foreign country)
10. Usual occupation Farmer

MOTHER FATHER
11. Industry or business _____
12. Name Abraham Baer
13. Birthplace Penn.
(City, town, or county) (State or foreign country)
14. Maiden name Lincy Mages
15. Birthplace Penn.
(City, town, or county) (State or foreign country)

16. (a) Informant Jeanette England
(b) Address Marceline Mo
17. (a) Burial (b) Date thereof Sept 6 - 1944
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Hyden

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? _____

18. (a) Signature of funeral director James M Faughn
(b) Address Marceline Mo
19. (a) 9-7-44 (b) P. P. Patruski M.D.
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)
(e) Means of injury 51
23. Signature W. C. Guarn (M.D. or other)
Address Bucklin Mo Date signed 9/6/44

1350

(Licensed Embalmer's Statement on Reverse Side)

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. 4088

P. O. Address Marceline 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.