

FILED FEB 5 1945
Registration District No. 317

Primary Registration District No. 3070

Registrar's No. 2817

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Webster Groves, (19) Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
617 E. Swon Ave
(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 Missouri (b) County St. Louis 91
(c) City or town Webster Groves (19) 7
(If outside city or town limits, write "RURAL")
(d) Street No. 617 E Swon Ave 6
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country 12

3. (a) PRINT NAME Harriett (Hallie) Bauer
FULL NAME

3. (b) If veteran, name war none
3. (c) Social Security No. none

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Albert Bauer
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased July 17 1874
(Month) (Day) (Year)

8. AGE: Years 70 Months 5 Days 28
If less than one day _____ hr. _____ min.

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

10. Usual occupation Nil

11. Industry or business _____

MOTHER FATHER
12. Name Carl C. Lishen
13. Birthplace Germany
(City, town, or county) (State or foreign country)
14. Maiden name Harriett Stofer
15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Albert Lishen
(b) Address 453 E Big Bend Webster Groves

17. (a) Burial (b) Date thereof 1/17/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Cemetery

18. (a) Signature of funeral director Mittelberg Fun. Homes
(b) Address Webster Groves (19) Mo.

19. (a) JAN 17 1945 (b) E. J. Mallavan
(Data received local health officer) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 15
year 1945 hour 6 minute A M.

21. I hereby certify that I attended the deceased from November 27, 1944 to January 15, 1945,
that I last saw her alive on January 13, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death: Carcinomatosis
Due to Cancer of the colon 7 Month

Due to 46e

Other conditions (Include pregnancy within 3 months of death)

Major findings: Adenoma of colon (obstructive) at splenic flexure
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 _____

Signature Edward C. Westrup (M. D. or other) M.D.
Address 204 E. Big Bend Webster Groves Date signed 1-15-45

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

674

274
5/45

109

FEB 8 1945

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

John M. Meyer

Licensed Embalmer No. *3288*

P. O. Address *3404 Adams Richmond 22 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.