

LED NOV 10 1945  
318

STANDARD CERTIFICATE OF DEATH  
1003

State File No.

Registrar's No.

9467

Registration District No.

Primary Registration District No.

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: City Sanitarium  
(If not in hospital or institution, write street number or location) 4 mos 6das.  
(d) Length of stay: In hospital or institution 77 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL") 3930 N. 25th St  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME CATHERINE BAUDE

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

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced Mar  
6. (b) Name of husband or wife William Baude 6. (c) Age of husband or wife if alive 70 years  
7. Birth date of deceased Sept. 7, 1868  
(Month) (Day) (Year)

8. AGE: Years 76 Months 7 Days 22 If less than one day hr. \_\_\_\_\_ min. 77 1 24

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name not known  
13. Birthplace not known 9  
(City, town, or county) (State or foreign country)  
14. Maiden name Not known  
(City, town, or county) (State or foreign country)  
15. Birthplace not known 9  
(City, town, or county) (State or foreign country)

16. (a) Informant Sanitarium Records

(b) Address 5400 Arsenal St

17. (a) Burial (b) Date thereof 11 3 45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Laurel Hill Gardens

18. (a) Signature of funeral director Suedmeyer & Sons

(b) Address 3934 N. 20 St.

19. (a) NOV 1 1945 (b) J. J. Brodeur  
(Date received by registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 31st  
year 1945 hour 4:40 minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from June 25 1945 to October 31, 1945  
that I last saw her er alive on October 31, 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death: Cardiac Decompensation 1945x  
Senility 1945x

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy No

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 Anthony K. Birch (M. D. or other) \_\_\_\_\_  
Address 5300 Arsenal Date signed 10/31/45

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

MOTHER FATHER

*Basile*

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**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 *Renneth W. Jones*.....

Licensed Embalmer No. *4224*.....

P. O. Address *3423 Clara*.....

**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.**