

DEPARTMENT OF COMMERCE THE STATE BOARD OF HEALTH OF MISSOURI  
BUREAU OF THE CENSUS 2 1946 STANDARD CERTIFICATE OF DEATH

7059

State File No. \_\_\_\_\_  
Registrar's No. 467

Registration District No. 367 Primary Registration District No. 6076

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

1. PLACE OF DEATH  
(a) County St. Louis  
(b) City or town Ballwin  
(c) Name of hospital or institution: Pine Crest Home #4  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 4 MO  
In this community yes  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Jacob Bachtold  
3. (b) If veteran, name war 10 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race W 6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife LULA 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased May 14 1872  
(Month) (Day) (Year)

8. AGE: Years 74 ~~72~~ Months 9 Days 5 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation CONDUCTOR

11. Industry or business PUBLIC SERVICE CO

12. Name Jacob Bachtold

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

14. Maiden name Barbara Wanner 9  
(City, town, or county) (State or foreign country)

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

16. (a) Informant Pine Crest Home

(b) Address Ballwin MO.

17. (a) BURIAL (b) Date thereof 2 25 46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY

18. (a) Signature of funeral director KRIEGERHAUSER

(b) Address 4228 SO. KINGSK. 9TH WAY

19. (a) 2-23-46 (b) E. M. Hanson MD  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State MO (b) County 000  
(c) City or town St. Louis 17  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4104 Arsenal 9  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 19  
year 46 hour 5 minute 45 P.M.  
21. I hereby certify that I attended the deceased from Feb 1  
1946 to Feb 19 1946

that I last saw him alive on Feb 18 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death chronic myocardiopathy senility

Due to generalized arteriosclerosis

Due to 930

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

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

Of autopsy \_\_\_\_\_

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 A. J. Mullin M.D. (M. D. number) 0

Address 3507 Poloma Date signed 2-20-46

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

MAR 4 1948

**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 Calvin D Mc Dermott

Licensed Embalmer No: 3027

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.**