

Registration District No. **230**

Primary Registration District No. **5-810**

1. PLACE OF DEATH:

(a) County **Montgomery Co.**
(b) City or town **Big Spring, Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
XX
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
(Specify whether
In this community **79-II-I6**
years, months or days)

3. (a) PRINT FULL NAME **Mrs. Henry Baar.**

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

4. Sex **Female** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife **Henry Baar.** 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased **Nov IIth, 1866**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
79 II I6 hr. min.

9. Birthplace **Near Big Spring, Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business

12. Name **Henry Lucksinger.**

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

14. Maiden name **Anna Schlindler.**

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

16. (a) Informant **Dr. Rich**

(b) Address **New Florence, Mo. RFD 3#**

17. (a) **Burial** (b) Date thereof **Oct 30th, 1946**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Big Spring, Mo. ME**

18. (a) Signature of funeral director **Barney Baar**

(b) Address **Americus, Mo.**

19. (a) **Oct. 29-46** (b) **Nona Lee Thompson**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri.** (b) County **Montgomery**
(c) City or town **Big Spring, Mo.**
(If outside city or town limits, write "RURAL")
(d) Street No.....
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct** day **27th** year **1946** hour **10** minute **45** P. M.

21. I hereby certify that I attended the deceased from **August 8** 19**46** to **October 27** 19**46** that I last saw her alive on **October 27** 19**46** and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic myocarditis and myocardial degeneration.** Duration **4 mos**

Due to **Arteriosclerotic nephritis and arthritis.** **3 yrs**

Due to **Generalized arteriosclerosis Sev. and diabetes.** **yrs.**

Other conditions **Senility.**
(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.....

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 **A. H. Thompson** (M. D. or other) **80**

Address **New Florence, Mo** Date signed **10/29/46**

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed 11/4/76

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.....

..... **D.B. Baker,**, Registered Apprentice No.,
working under my personal supervision.

Signed..... *D B Baker*

Licensed Embalmer No. **3375**

P. O. Address **Americus, 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 230

Primary Registration District No. 5810

Registrar's No. 13

1. PLACE OF DEATH:

(a) County Montgomery
(b) City or town Bay Spring
(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

3. (a) PRINT FULL NAME

Mrs. Magdalena Baur

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

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

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

7. Birth date of deceased Nov. 11
(Month) (Day) (Year)

8. AGE: Years 29 Months 1 Days 1 If less than one day
hr. _____ min. _____

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

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 _____
(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) Mrs. Nana Lee Thompson
(Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct Day 7
year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;

that I last saw him _____ 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 _____

SUPPLEMENTARY

34228