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K26390

FILED JUL 16 1947

Registration District No. 343

Primary Registration District No. 6154

Registrar's No. 27

1. PLACE OF DEATH

(a) County Hodgdon
(b) City or town Gray Ridge Mo.
(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 of location)
(d) Length of stay: In hospital or institution
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Luiman Carl Bauer

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

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

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

7. Birth date of deceased June 14 1947
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
23 hr. min.

9. Birthplace Gray Ridge Mo
(City, town, or county) (State or foreign country)

10. Usual occupation none

11. Industry or business

MOTHER FATHER

12. Name John Bauer

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

14. Maiden name Mary Jones

15. Birthplace 22nd
(City, town, or county) (State or foreign country)

16. (a) Informant John Bauer

(b) Address Gray Ridge Mo

17. (a) Burial (b) Date thereof July 8 47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Dayton

18. (a) Signature of funeral director

(b) Address

19. (a) July 9 1947 (b) Kate Handy
(Date received legal registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Hodgdon
(c) City or town Gray Ridge Mo
(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 July day 8 1947
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from July 8 1947 to July 8 47
that I last saw him alive on _____ 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Congenital Heart Lesion

Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy 157E

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? 0

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature [Signature] (M. D. or other) _____
Address Gray Mo Date July 8 47

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

RECEIVED
District Health Office No. 2,
District File Number 747-927
Date Filed 7-14-44

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.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.