

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 30655

FILED SEP 30 1947

Registration District No. 324

Primary Registration District No. 5224

Registrar's No. 147

1. PLACE OF DEATH:

(a) County Cass
(b) City or town Grand River Twp.
(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. 30 years. (Specify whether years, months or days)

3. (a) PRINT FULL NAME GEORGE BAER

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Alvena Baer 6. (c) Age of husband or wife if alive 64 years
7. Birth date of deceased Dec 15 1874 (Month) (Day) (Year)

8. AGE: Years 72 Months 9 Days 24 If less than one day hr. min.

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

10. Usual occupation farmer

11. Industry or business

12. Name Clemence Baer

13. Birthplace St. Louis (City, town, or county) Mrs. (State or foreign country)

14. Maiden name Waters

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

16. (a) Informant MRS. GEO. BAER

(b) Address Harrisonville Mo.

17. (a) burial (Burial, cremation, or removal) (b) Date thereof Sept 26 1947 (Month) (Day) (Year)

(c) Place: burial or cremation Orion Cemetery

18. (a) Signature of funeral director RUNNENBURGER'S

(b) Address HARRISONVILLE, MO.

19. Sept. 26, 1947 (Date received local registrar) (b) Laura J. Jones (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Cass
(c) City or town Harrisonville Rural (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 Sept day 24 year 1947 hour minute M.

21. I hereby certify that I attended the deceased from April 1947 to Sept 24 1947, that I last saw him alive on Sept 24 1947 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Collapse due to H. of A. H. Duration

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 138

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 Harry B. Newsum (M. D. or other)

Address Harrisonville, Mo. Date signed 9-26-47

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

Dr N.

(Licensed Embalmer's Statement on Reverse Side)

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.....

Ernest R. Remmenburger

Licensed Embalmer No. *3368*

P. O. Address. *Harrisonville 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.