

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **31816**
Registrar's No. **43**

FILED SEP 12 1947
Registration District No. **5708**

Primary Registration District No. **5708**

1. PLACE OF DEATH:

(a) County **Marion County**
(b) City or town **Brinktown**
(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 **55 yrs** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Barbara Bauer.**

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

4. Sex **Female** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **married**
6. (b) Name of husband or wife **Joseph Bauer.** 6. (c) Age of husband or wife if alive **81** years
7. Birth date of deceased **December 28 1871** (Month) (Day) (Year)

8. AGE: Years **75** Months **8** Days **14** If less than one day hr. min.

9. Birthplace **Richfountain Mo.** (City, town, or county) (State or foreign country)

10. Usual occupation **House wife**

11. Industry or business

12. Name **John Welchmeyer.**
13. Birthplace **Germany** (City, town, or county) (State or foreign country)

14. Maiden name **Elizabeth Dill**
15. Birthplace **Richfountain Mo.** (City, town, or county) (State or foreign country)

16. (a) Informant **German Bauer.**
(b) Address **Brinktown**

17. (a) **Burial** (b) Date thereof **Sept. 13 1947** (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Brinktown Cemetery**

18. (a) Signature of funeral director **H. H. Shop**
(b) Address **Meta Mo**

19. (a) **472-47** (b) **Pauline Howard** (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Marion County**
(c) City or town **Brinktown** (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 **Sept.** day **11** year **1947** hour **2:10** minute **P.** M.

21. I hereby certify that I attended the deceased from **August 24 1946** to **Sept. 9 1947**; that I last saw her alive on **Sept. 9 1947**; and that death occurred on the date and hour stated above.

Immediate cause of death **Cancer of liver** Duration **?**

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **H64**

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 **2**
Signature **P. C. Howard** (M. D. or other) **P.O.**
Address **Ienna, Missouri** Date signed **9/12/47**

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed SEP 18 1947

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

H H Strop

Licensed Embalmer No.

2924

P. O. Address

Meta 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.