

FILED APR 30 1948

318

1003

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
DEACONESS 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 DAYS
(Specify whether years, months or days)
In this community 2 DAYS
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County JEFFERSON 50
(c) City or town HIGH RIDGE 0
(If outside city or town limits, write "RURAL")
(d) Street No. N. R. (If rural, give location) 9 1
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month APRIL day 21
year 1948 hour 9 minute 15 P. M.

21. I hereby certify that I attended the deceased from April 19, 1948 to April 21, 1948
that I last saw him alive on 4-21, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Congestion heart failure
Due to arterio-sclerotic heart disease
Duration a few weeks
Due to arterio-sclerotic heart disease Indef.

Other conditions (Include pregnancy within 3 months of death)
None

Major findings:
Of operations _____

Of autopsy arterio-sclerotic heart disease
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) Means of injury fall
23. Signature Walter (M. D. or other) _____
Address St. Louis Mo Date signed 4-23-48

3. (a) PRINT FULL NAME WILLIAM L. BAUR

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

4. Sex M 5. Color or race W
6. (a) Single, widowed, married, divorced WIDOWED
6. (b) Name of husband or wife ELSIE MOHR BAUR
6. (c) Age of husband or wife if alive Deed years
7. Birth date of deceased 7 31 1864
(Month) (Day) (Year)

8. AGE: Years 78 Months 8 Days 20
If less than one day hr. 4 min. 4

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

10. Usual occupation MINISTER

11. Industry or business 4

12. Name GOTTLOR BAUR

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

14. Maiden name FAYLINE FISCHER

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

16. (a) Informant Dr. A. Baur M.D.

(b) Address 324 STARBU COURT

17. (a) BURIAL (b) Date thereof 4 24 48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Peter's Cem

18. (a) Signature of funeral director Walter

(b) Address Wesley Grove 19 Mo

19. (a) APR 23 1948 (b) J. F. Predest
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

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 *John S. Denny*
Licensed Embalmer No. *41942*

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.