

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 27769

FILED SEP 9 1949

BIRTH NO. _____		REG. DIST. NO. 310		PRIMARY REG. DIST. NO. 6051		Registrar's No. 15-9			
1. PLACE OF DEATH a. COUNTY St. Charles				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Illinois b. COUNTY St. Clair					
b. CITY (If outside corporate limits, write RURAL and give township) St. Charles				c. CITY (If outside corporate limits, write RURAL and give township) Summerfield					
d. FULL NAME OF HOSPITAL OR INSTITUTION Evangelical Emmaus Home				d. STREET ADDRESS _____					
3. NAME OF DECEASED (Type or Print) Lydia		a. (First)		b. (Middle)		c. (Last) Baer			
4. DATE OF DEATH (Month) (Day) (Year) Aug. 22, 1949		5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) Single			
8. DATE OF BIRTH Aug. 18, 1890		9. AGE (In years last birthday) 59		10. MONTHS 0		11. DAYS 4			
12. IF UNDER 1 YEAR Hours Min.		13. IF UNDER 12 HRS. Hours Min.		14. BIRTHPLACE (State or foreign country) Summerfield, Illinois		15. CITIZEN OF WHAT COUNTRY? U.S.A.			
16. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		17. KIND OF BUSINESS OR INDUSTRY -----		18. FATHER'S NAME Jacob Baer		19. MOTHER'S MAIDEN NAME Eliza Hamburg			
20. NAME OF HUSBAND OR WIFE -----		21. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) -----		22. SOCIAL SECURITY NO. -----		23. INFORMANT'S SIGNATURE OR NAME Rev. Theophil Stoerker, St. Charles, Mo			
24. ADDRESS -----		25. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death. 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Dilatation of heart ANTECEDENT CAUSES Metastasis of Cancer to liver & lungs. DUE TO (b) Post operative Cancer of Breast. DUE TO (c) ----- 2. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 170X		26. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH 24 hrs		27. DATE OF OPERATION 5/8/46		28. MAJOR FINDINGS OF OPERATION Cancer of Breast (rt side)	
29. AUTOPSY? YES ☐ NO ☒		30. ACCIDENT SUICIDE HOMICIDE no.		31. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -----		32. CITY, TOWN, OR TOWNSHIP (COUNTY) (STATE)			
33. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		34. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐		35. HOW DID INJURY OCCUR? -----		36. I hereby certify that I attended the deceased from May 8 th , 1949, to Aug 22 nd , 1949 that I last saw the deceased alive on Aug 22 nd , 1949 and that death occurred at 10 P.m., from the causes and on the date stated above.			
37. SIGNATURE C. Erich Schurz MD.		(Degree of title)		38. ADDRESS St. Charles Mo.		39. DATE SIGNED 8/27/49			
40. BURIAL, CREMATION, REMOVAL (Specify) Removal		41. DATE Aug. 23, 1949		42. NAME OF CEMETERY OR CREMATORY O'Fallon Cemetery		43. LOCATION (City, town, or county) (State) O'Fallon, Illinois			
44. DATE REC'D BY LOCAL REG. 9-2-49		45. REGISTRAR'S SIGNATURE Fannie Hemmick		46. FUNERAL DIRECTOR'S SIGNATURE 284 Wackman		47. ADDRESS Dan St. Charles			

WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

RECEIVED
SEP 6 1919
District Health Officer No. 9,
District File Number

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed _____

Signed _____
Student Embalmer

Licensed Embalmer No. _____

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.