No. 300
10.48

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

FILED SEP 24 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 31587

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 7965

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St Louis
c. LENGTH OF STAY (In this place): Life
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Enroute to City Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: —
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St Louis
d. STREET ADDRESS (If rural, give location): 1522 So. 3rd St (Rear)

3. NAME OF DECEASED (Type or Print)
a. (First): Joseph
b. (Middle):
c. (Last): Bauer

4. DATE OF DEATH (Month) (Day) (Year): Sept 12 - 1949

5. SEX: M
6. COLOR OR RACE: Wh
7. MARRIED, NEVER-MARRIED, WIDOWED, DIVORCED (Specify): W
8. DATE OF BIRTH: Unknown
9. AGE (In years last birthday): About 70 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (State or foreign country): St Louis Mo.
12. CITIZEN OF WHAT COUNTRY?: —

13a. FATHER'S NAME: Unknown
13b. MOTHER'S MAIDEN NAME: Unknown
14. NAME OF HUSBAND OR WIFE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): —
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S SIGNATURE OR NAME: Ernestine Bitschel
ADDRESS: 1524 So. 3rd St.

18. 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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____ — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis Cardiac
DUE TO (c) Hypertrophy. Prostatic Hypertrophy

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at 6:25 P. m., from the causes and on the date stated above.*

23a. SIGNATURE: Patrick E Taylor R Coroner (Degree or title)
23b. ADDRESS: 1300 Clark
23c. DATE SIGNED: 9-13-49

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9-15-49
24c. NAME OF CEMETERY ~~OR CREMATORY~~: Mount Hope
24d. LOCATION (City, town, or county) (State): St. Louis County Mo.

DATE REC'D BY LOCAL REG.: SEP 14 1949
REGISTRAR'S SIGNATURE: J B Lasater
25. FUNERAL DIRECTOR'S SIGNATURE: A W McLaughlin
ADDRESS: 2301 Lafayette

(Licensed Embalmer's Statement on Reverse Side)

Remove

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.

Student .....
Student Embalmer

Signed C. W. Cooper

Licensed Embalmer No. 3830

P. O. Address 2301 Lafayette

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

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