

FILED OCT 19 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6076 Registrar's No. 4116

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>Jennings</b>	c. LENGTH OF STAY (in this place) <b>5 YRS.</b>	c. CITY (If outside corporate limits, write RURAL and give township) <b>Jennings</b>	<b>9</b>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>5416 Hamilton Ave.</b>		d. STREET ADDRESS (If rural, give location) <b>5416 Hamilton Ave.</b>	

3. NAME OF DECEASED (Type or Print) <b>Mary</b>	a. (First)	b. (Middle) <b>Ide</b>	c. (Last) <b>Bakula</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Oct. 9 1949</b>
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>July 29, 1880</b>	9. AGE (In years last birthday) <b>69</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 4 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>St. Louis CO. Missouri</b>		12. CITIZEN OF WHAT COUNTRY?	

13a. FATHER'S NAME <b>George Balch</b>	13b. MOTHER'S MAIDEN NAME <b>Margaret Schmering</b>	14. NAME OF HUSBAND OR WIFE <b>Charles J. Bakula Sr.</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Charles J. Bakula, 5416 Hamilton Ave.</b>	ADDRESS
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Bronchial Asthma</b>		<b>years</b>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Hypertension</b>		<b>years</b>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<b>444A</b>	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>444.X</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR
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22. I hereby certify that I attended the deceased from 1946 to Oct 9, 1949, that I last saw the deceased alive on Oct 9, 1949, and that death occurred at 11 A. m., from the causes and on the date stated above.

23a. SIGNATURE <i>[Signature]</i>	(Degree or title) <b>M.D.</b>	23b. ADDRESS <b>6204 W. Florissant</b>	23c. DATE SIGNED <b>Oct 10-49</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>Oct. 12, 1949</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>
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DATE REC'D BY LOCAL REG. <b>10-11-49</b>	REGISTRAR'S SIGNATURE <i>[Signature]</i>	25. FLUNERAL DIRECTOR'S SIGNATURE <b>Cullinane Bros.</b>	ADDRESS <b>3320 N. Kingshighway</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

**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 *Fred Frick* .....

Licensed Embalmer No. *3186* .....

P. O. Address. *St. Louis 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.