

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

FILED JUN 9 1950

State File No. **17955**
4810

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS,		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis,	
d. FULL NAME OF HOSPITAL OR INSTITUTION City Hospital..		e. STREET ADDRESS (If rural, give location) 4050 De Tonty Street.	

3. NAME OF DECEASED (Type or Print)	a. (First) LAURA	b. (Middle) FRIEDA	c. (Last) BAEPLER,	4. DATE OF DEATH (Month) (Day) (Year) May 29, 1950
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5. SEX Female.	6. COLOR OR RACE White.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single.	8. DATE OF BIRTH September 24, 1877.	9. AGE (In years last birthday) 72.	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hour	IF UNDER 24 HRS. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home.	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) St. Louis, Missouri.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Gus Baepler.	13b. MOTHER'S MAIDEN NAME Emma Gessler.	14. NAME OF HUSBAND OR WIFE None.
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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) no.	16. SOCIAL SECURITY NO. none.	17. INFORMANT'S SIGNATURE OR NAME George Gessler, 408 Olive Street.	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, asthenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Subdural Hematoma; suffered when deceased fell down stairs and struck concrete pavement in the rear of her head at 4050 De Tonty St on May 29, 1950 at about 1:45 pm		INTERVAL BETWEEN ONSET AND DEATH
	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 Accident 800	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT (Specify) Accident	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) St Louis Mo E 90 21
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) May 29 50 1:45 p.m.	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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **3:25 P. m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Patrick E. Taylor, Coroner	23b. ADDRESS 1300 Clark.	23c. DATE SIGNED 5.29.50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial.	24b. DATE 6/1/50.	24c. NAME OF CEMETERY OR CREMATORY Old St. Marcus Cemetery.	24d. LOCATION (City, town, or county) (State) 6638 Gravois Ave.,
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DATE RECD BY LOCAL HEALTH DEPT. June 21 1950	REGISTRAR'S SIGNATURE J. A. Sauter	25. FUNERAL DIRECTOR'S SIGNATURE C.R. Lupton & Sons; 7233 Delmar Blvd.	ADDRESS
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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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed Arnold W. Schoene

Signed.....
Student Embalmer

Licensed Embalmer No. 3864

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.