

FILED OCT 5 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31530

State File No.

BIRTH NO.		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 7884			
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis					
d. FULL NAME OF HOSPITAL OR INSTITUTION 3108 Osceola				d. STREET ADDRESS 3108 Osceola					
3. NAME OF DECEASED (Type or Print) Lucille			a. (First)		b. (Middle)		c. (Last) Bauer		
4. DATE OF DEATH (Month) (Day) (Year) Sept 15, 1950									
5. SEX female		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH Feb 11, 1887		9. AGE (in years last birthday) 63	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) St Louis, Mo. 0			12. CITIZEN OF WHAT COUNTRY?		
13a. FATHER'S NAME Johann Scheuhammer			13b. MOTHER'S MAIDEN NAME Gross			14. NAME OF HUSBAND OR WIFE George Bauer			
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 Bauer				ADDRESS 3108 Osceola	
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Ovary with general metastasis ANTECEDENT CAUSES <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i> DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>						INTERVAL BETWEEN ONSET AND DEATH Jan 1 - 50	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR 175X					
22. I hereby certify that I attended the deceased from Jan 1, 1950 , to Sept 15, 1950 , that I last saw the deceased alive on Sept 15, 1950 , and that death occurred at 5:30 m., from the causes and on the date stated above.									
23a. SIGNATURE W. Huberters M.D. (Degree or title)				23b. ADDRESS 3608 S Grand Ave. St Louis Mo		23c. DATE SIGNED 9/16/50			
24a. BURIAL, CREMATION, REMOVAL (Specify) burial		24b. DATE 9/18/50		24c. NAME OF CEMETERY OR CREMATORY Sunset Burial Park		24d. LOCATION (City, town, or county) (State) Affton, Mo.			
DATE REC'D BY LOCAL REG. SEP 18 1950		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE J L Ziegenhein & Sons		ADDRESS 7027 Gravois			

(Licensed Embalmer's Statement on Reverse Side)

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

Francis J. Swann
2500

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 *Francis J. Swann*

Signed.....
Student Embalmer

Licensed Embalmer No. *2245*

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.