

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

43602

State File No.

No. 300
10-65

FILED JAN 10 1952

BIRTH NO. _____ REG. DIST. NO. 37 PRIMARY REG. DIST. NO. 676 Registrar's No. 3924

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Koch (rural)</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Robert Koch Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>3301 Olive</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Christopher</u> b. (Middle) <u>Frank</u> c. (Last) <u>Bauer</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>12-7-51</u>
----------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>6-8-99</u>	9. AGE (In years last birthday) <u>52</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours	IF UNDER 24 HRS. Min.
--------------------	-------------------------------	----------------------------------------------------------------------	--------------------------------	-------------------------------------------	---------------------------	--------------------------	---------------------------	--------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chauffeur for Black & White Taxi</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>St. Louis, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
--------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------	--------------------------------------------------------------------	-----------------------------------------------

13a. FATHER'S NAME <u>Henry Bauer</u>	13b. MOTHER'S MAIDEN NAME <u>Anne Buska</u>	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) <u>No</u>	16. SOCIAL SECURITY NO. <u>493-07-0058</u>	17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS <u>Hospital Records, Robt. Koch Hosp.</u>
-----------------------------------------------------------------------------------------------------------------------	-----------------------------------------------	--------------------------------------------------------------------------------------------

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pulmonary Hemorrhage</u>		4 yrs (?)
	ANTECEDENT CAUSES <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i> DUE TO (b) <u>Pulmonary Tuberculosis</u> DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i> <u>Arteriosclerotic Heart Disease</u> <u>Rheumatoid spondylitis</u>		??	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>002X</u>	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?
--------------------------------------------------------	--------------------------------------------------------------------------------------------------------	----------------------------

22. I hereby certify that I attended the deceased from 9-11-51 to 12-7-, 1951, that I last saw the deceased alive on 12-7-, 1951, and that death occurred at 11:50A. from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Ellis J. Lipsitz</u> M.D.	23b. ADDRESS <u>Robert Koch Hospital</u>	23c. DATE SIGNED <u>12-7-51</u>
------------------------------------------------------------------	---------------------------------------------	------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>12-10-51</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Lake Charles</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis County, Mo.</u>
-------------------------------------------------------------	------------------------------	-----------------------------------------------------------	-------------------------------------------------------------------------------

DATE REC'D BY LOCAL REG. <u>12-8-51</u>	REGISTRAR'S SIGNATURE <u>Herbert P. Jomke</u>	25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS <u>Albert H. Hoppe-4700 Washington Blvd.</u>
--------------------------------------------	--------------------------------------------------	----------------------------------------------------------------------------------------------

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 me

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed W. W. Wilkinson

Licensed Embalmer No. 3576

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.