

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **19166**  
**5292**

FILED JUN 10 1953

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN <b>St. Louis</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>657 Bittner St.,</b>				e. STREET ADDRESS (If rural, give location) <b>8 657 Bittner St.,</b>			
3. NAME OF DECEASED (Type or Print) <b>Theophelia BAUMANN</b>			a. (First) _____ b. (Middle) _____ c. (Last) _____			4. DATE OF DEATH (Month) (Day) (Year) <b>May 26th, 1953</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>widowed 2</b>	8. DATE OF BIRTH <b>April 20th 1865</b>		9. AGE (In years last birthday) <b>88</b>	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) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <b>Germany 4</b>		12. CITIZEN OF WHAT COUNTRY? _____	
13a. FATHER'S NAME <b>unknown</b>		13b. MOTHER'S MAIDEN NAME <b>unknown</b>		14. NAME OF HUSBAND OR WIFE <b>August Baumann</b>			
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 ADDRESS <b>Mrs. Alma Vogel, 657 Bittner St.,</b>			
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Chronic myocarditis</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>not known</b> DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <b>5 years</b>	
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>none</b>					
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <b>none</b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>none</b>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>St. Louis Co., Mo.</b>			
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? <b>4222</b>			
22. I hereby certify that I attended the deceased from <b>Dec 10, 1912</b> , to <b>May 26, 1953</b> , that I last saw the deceased alive on <b>May 25, 1953</b> , and that death occurred at <b>2:30 A.M.</b> , from the causes and on the date stated above.							
23a. SIGNATURE <b>H. F. Miller M.D.</b> (Degree or title)				23b. ADDRESS <b>8400 Broadway</b>		23c. DATE SIGNED <b>5-26-53</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>		24b. DATE <b>May 29th, 1953</b>		24c. NAME OF CEMETERY OR CREMATORY <b>St. Johns Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis Co., Mo.</b>	
DATE REC'D BY LOCAL REG. <b>MAY 26 1953</b>		REGISTRAR'S SIGNATURE <b>J. Earl Smith, M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>DIEDRICH FUNERAL HOME, 8319 Hallsferry</b>			

B.P. (Licensed Embalmer's Statement on Reverse Side)

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.....  
Signature of Student Embalmer

Signed *John S. Blum*.....  
Licensed Embalmer No. *41*  
P. O. Address *St. Lo*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.