

FILED APR 21 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **13784**
Registrar's No. **3080**

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		State File No. 13784		Registrar's No. 3080			
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. LENGTH OF STAY (in this place) 4 yrs		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis						
d. FULL NAME OF HOSPITAL OR INSTITUTION 5323 Sutherland Ave.				d. STREET ADDRESS (If rural, give location) 5323 Sutherland Ave.							
3. NAME OF DECEASED (Type or Print) Pauline			s. (First)		b. (Middle) Manar		c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) April 4 1954		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH Sept 20 1875		9. AGE (In years last birthday) 79		10. UNDER 1 YEAR Months 6 Days 14	11. UNDER 1 MRS. Hours _____ Mts. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (City and State or Foreign Country) Milwaukee Wisconsin			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13a. FATHER'S NAME William Baumgartner			13b. MOTHER'S MAIDEN NAME Margaret Ziegler			14. NAME OF HUSBAND OR WIFE Albert Manar					
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 ADDRESS Genevieve McCaul 5323 Sutherland						
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) Arteriosclerotic Heart Disease ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							INTERVAL BETWEEN ONSET AND DEATH April 1954		
19a. DATE OF OPERATION None		19b. MAJOR FINDINGS OF OPERATION _____							20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT SUICIDE HOMICIDE (Specify) No		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____			21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 420.0						
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? _____						
22. I hereby certify that I attended the deceased from April 1953 , to April 4, 1954 , that I last saw the deceased alive on April 4, 1954 , and that death occurred at 7:35 A.M. , from the causes and on the date stated above.											
23a. SIGNATURE (Degree or title) Bernard T. Keon M.D.				23b. ADDRESS 4755 Morganford Road St. Louis 1, Mo.				23c. DATE SIGNED 4/1/54			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Apr 6/1954		24c. NAME OF CEMETERY OR CREMATORY St. Peter & Paul Cem.		24d. LOCATION (City, town, or county) (State) St. Louis Mo.					
DATE REC'D BY LOCAL REG. APR 6 1954		REGISTRAR'S SIGNATURE Carly Smith MO			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS John L. Ziegenhein & Sons 7027 Gravois						

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

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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 _____

Donald E. Benz

Student Embalmer No. *4862*

working under my personal supervision.

Student *Donald E. Benz*
Student Embalmer

Signed *B. P. Kidwell*

Licensed Embalmer No. *3877*

P. O. Address *7027 Gravois*

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.