

FILED JUN 24 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH20167  
State File No. 4459

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. <b>4459</b>	
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) <b>St. Louis</b>		c. LENGTH OF STAY (In this place) <b>1 month</b>		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>Victoria Nursing Home</b>				e. STREET ADDRESS (If rural, give location) <b>2007 Virginia</b>		<b>21790</b>	
3. NAME OF DECEASED (Type or Print)		a. (First) <b>John</b>		b. (Middle) <b>Phillip</b>		c. (Last) <b>Bauer</b>	
4. DATE OF DEATH		(Month) (Day) (Year)		<b>May 17, 1954</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>March 20, 1867</b>		9. AGE (In years last birthday) Months Days Hours Min. <b>87</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Mo. Pac. Railroad</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Gasconade County, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>John Bauer</b>		13b. MOTHER'S MAIDEN NAME <b>Elizabeth Schmidt</b>		14. NAME OF HUSBAND OR WIFE <b>Amanda A. Bauer</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>Amanda A. Bauer, 2007 Virginia,</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.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Concomitant of Prostate</b>  ANTECEDENT CAUSES <b>Arteriosclerosis, H.P. Dis.</b>  Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (c)  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Arteriosclerosis, gen.</b>		MEDICAL CERTIFICATION  INTERVAL BETWEEN ONSET AND DEATH			
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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>177x</b>			
22. I hereby certify that I attended the deceased from <b>2-15-54</b> , 19 <b>54</b> , to <b>5/17/54</b> , 19 <b>54</b> , that I last saw the deceased <b>alive on 5-14-54</b> , 19 <b>54</b> , and that death occurred at <b>9:30 a.m.</b> , from the causes and on the date stated above.							
23a. SIGNATURE <b>Phillip Knauer, M.D.</b>				23b. ADDRESS <b>16 Plaza Heights Village</b>		23c. DATE SIGNED	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>May 19, 1954</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis County, Missouri.</b>	
DATE REC'D BY LOCAL REG. <b>MAY 18 1954</b>		REGISTRAR'S SIGNATURE <b>J. Carl Smith, M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>C. Hoffmeister Colonial Mortuary, Chippewa</b>			

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

Dr. Kromer

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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 ....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Linn O. Hoffmann*.....

Licensed Embalmer No. 387

P. O. Address 7814 St

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.