

FILED DEC 13 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36541

State File No.

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 1279

1. PLACE OF DEATH a. COUNTY <p style="text-align: center;">Buchanan</p>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <p style="text-align: center;">Kansas</p>		b. COUNTY <p style="text-align: center;">Doniphan</p>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <p style="text-align: center;">St. Joseph</p>		c. LENGTH OF STAY (in this place) <p style="text-align: center;">6 days</p>		c. CITY OR TOWN <p style="text-align: center;">Troy</p>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <p style="text-align: center;">Missouri Methodist Hospital</p>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <p style="text-align: center;">Missouri Methodist Hospital</p>		e. STREET ADDRESS (If rural, give location) <p style="text-align: right;">815 S</p>			

3. NAME OF DECEASED (Type or Print) a. (First) <p style="text-align: center;">Louis</p>			b. (Middle) <p style="text-align: center;">H.</p>			c. (Last) <p style="text-align: center;">Bahr</p>			4. DATE OF DEATH (Month) (Day) (Year) <p style="text-align: center;">November 27, 1954</p>		
5. SEX <p style="text-align: center;">male</p>		6. COLOR OR RACE <p style="text-align: center;">white</p>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <p style="text-align: center;">divorced</p>		8. DATE OF BIRTH <p style="text-align: center;">November 1, 1905</p>			9. AGE (In years last birthday) Months Days Hours Min. <p style="text-align: center;">49</p>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <p style="text-align: center;">farmer</p>			10b. KIND OF BUSINESS OR INDUSTRY <p style="text-align: center;">farm</p>			11. BIRTHPLACE (City and State or Foreign Country) <p style="text-align: center;">Kansas</p>			12. CITIZEN OF WHAT COUNTRY? <p style="text-align: center;">USA</p>		

13a. FATHER'S NAME <p style="text-align: center;">Alcid H. Bahr</p>		13b. MOTHER'S MAIDEN NAME <p style="text-align: center;">Anna Kosmann</p>		14. NAME OF HUSBAND OR WIFE <p style="text-align: center;">unknown</p>	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <p style="text-align: center;">no</p>		16. SOCIAL SECURITY NO. <p style="text-align: center;">513-01-6049</p>		17. INFORMANT'S SIGNATURE OR NAME <p style="text-align: center;">Mr. Alcid Bahr, Troy, Kansas</p>		ADDRESS	
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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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute Cerebral edema</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
		ANTECEDENT CAUSES DUE TO (b) <u>Delirium</u>				4 "	
		DUE TO (c) <u>Acute & chronic alcoholism</u>				Sw. years	
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>strangulated left inguinal hernia, omentum & lg bowel section left side of transverse colon</u>				10 days	

19a. DATE OF OPERATION <p style="text-align: center;">11/22/54</p>		19b. MAJOR FINDINGS OF OPERATION <p style="text-align: center;">Rupture of gr. omentum & section left side of transverse colon</p>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) <p style="text-align: center;">5615</p>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		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 11-22, 1954, to 11-26, 1954, that I last saw the deceased alive on 11-26, 1954 and that death occurred at 7:30 a.m., from the causes and on the date stated above.

23a. SIGNATURE <p style="text-align: center;">Howard S. Jack Jr., M.D.</p>		(Degree or title)		23b. ADDRESS <p style="text-align: center;">420 N. 84th Street, Missouri</p>		23c. DATE SIGNED <p style="text-align: center;">12/3/54</p>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <p style="text-align: center;">removal</p>		24b. DATE <p style="text-align: center;">11/27/1954</p>		24c. NAME OF CEMETERY OR CREMATORY <p style="text-align: center;">Christ Lutheran</p>		24d. LOCATION (City, town, or county) (State) <p style="text-align: center;">Troy, Kansas</p>	
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DATE REC'D BY LOCAL REG. <p style="text-align: center;">Dec 9, 1954</p>		REGISTRAR'S SIGNATURE <p style="text-align: center;">Kathryn M. Allison</p>		485		25. FUNERAL DIRECTOR'S SIGNATURE <p style="text-align: center;">Heaton-Bowman</p>		ADDRESS <p style="text-align: center;">St Joseph Mo.</p>	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

For grave

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 *Regina Wood*

Licensed Embalmer No. *380*

P. O. Address *319 So 10th 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.