

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **18508**
2399

FILED JUN 22 1955

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. <u>2399</u>	
1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. LENGTH OF STAY (in this place) 35 yrs		c. CITY OR TOWN Kansas City		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 St. Mary's Hospital				e. STREET ADDRESS (If rural, give location) 1224 Linwood			
3. NAME OF DECEASED (Type or Print) a. (First) Cecilia b. (Middle) _____ c. (Last) Baer			4. DATE OF DEATH (Month) (Day) (Year) 6-4-55				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 9-18-1862		9. AGE (In years last birthday) 92	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 10 HRS. Hours _____ Mins. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (City and State or Foreign Country) Cincinnati, Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Sigmund Levi		13b. MOTHER'S MAIDEN NAME Sarah (Unknown)		14. NAME OF HUSBAND OR WIFE Simon Baer			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Bernard L. Baer ADDRESS 1224 Linwood			
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) Congestive Heart Failure ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) Arterio-sclerosis II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 3 hrs 10 years 7 years 4200	
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? _____			
22. I hereby certify that I attended the deceased from <u>April</u> , 19 <u>48</u> , to <u>June 4</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5-27</u> , 19 <u>55</u> , and that death occurred at <u>3:50 P.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE Robert M. Parker (Degree or title) M.D.				23b. ADDRESS 520 Argyle Bldg		23c. DATE SIGNED 6-4-55	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 6-4-55		24c. NAME OF CEMETERY OR CREMATORY Cincinnati, Ohio		24d. LOCATION (City, town, or county) (State) Cincinnati, Ohio	
DATE REC'D BY LOCAL REG. 6-4-55		REGISTRAR'S SIGNATURE Merna Minshall		25. FUNERAL DIRECTOR'S SIGNATURE Melody-McGilley-Eylar ADDRESS 1800 E Linwood			

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

Original

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 *James E. Hasler*.....

Licensed Embalmer No. *45*

P. O. Address *K.C.M.*

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.

11/1/19