

FILED APR 30 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **14452**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **3724**

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. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
c. LENGTH OF STAY (In this place) 6 yrs.		d. STREET ADDRESS (If rural, give location) 2024 Blendon Pl.	
d. FULL NAME OF HOSPITAL OR INSTITUTION 2024 Blendon Pl.		4	

3. NAME OF DECEASED (Type or Print) BERTHA BAUMBACH			4. DATE OF DEATH April 12, 1956		
a. (First)	b. (Middle)		c. (Last)	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	
5. SEX F	6. COLOR OR RACE W	8. DATE OF BIRTH 6-15-1888	9. AGE (In years last birthday) 67	if UNDER 1 YEAR Months 9	if UNDER 24 HRS. Days 17 Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Housewife		10b. KIND OF BUSINESS OR INDUSTRY At home		11. BIRTHPLACE (City and State or Foreign Country) Clayton, Mo.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					

13a. FATHER'S NAME GEORGE GRAMPP		13b. MOTHER'S MAIDEN NAME MARY L. DETWEILER		14. NAME OF HUSBAND OR WIFE HENRY M. BAUMBACH	
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 Marion Grampp, above	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION Coronary thrombosis			INTERVAL BETWEEN ONSET AND DEATH sudden
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary thrombosis		Essential hypertension			5 yrs.
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) Essential hypertension			
DUE TO (c)					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing 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?	
		m.		5-10-13 11-12-56	

22. I hereby certify that I attended the deceased from **5/10 1953**, to **4/12 1956**, that I last saw the deceased alive on **1/16 1956**, and that death occurred at **9:30 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE I. J. Flance (Degree or title) MD		23b. ADDRESS 4652 Maryland Ave. St. Louis, Mo.		23c. DATE SIGNED 4-13-1956	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		24b. DATE 4-11-1956		24c. NAME OF CEMETERY OR CREMATORY Valhalla Crematory	
24d. LOCATION (City, town, or county) (State) St. Louis, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE JAY B. SMITH, Maplewood, Mo. ADDRESS _____			

DATE REC'D BY LOCAL REG. **APR 16 1956** REGISTRAR'S SIGNATURE **J. Carl Smith MD** (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
Student Embalmer

Signed

J.P. Burgess

Licensed Embalmer No.

4029

P. O. Address

Maplewood

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.