THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-014665
STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 4048

FILED MAY 11 1959

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN: St. Louis — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION: 8750 Oriole Avenue — Length of stay in 1b: 1 month

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: St. Louis — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 4582 Davison Avenue — Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First: Anna; Middle: ; Last: Bauer

4. DATE OF DEATH: Month: April; Day: 24; Year: 1959

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED [ ] **NEVER MARRIED** [ ] **WIDOWED** [X] **DIVORCED** [ ]

8. DATE OF BIRTH: October 4, 1874

9. AGE (In years last birthday): 84

IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (City and state or country): St. Louis, Missouri

12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: Herman Glasker

13b. MOTHER'S MAIDEN NAME: Johanna Fleir

14. NAME OF HUSBAND OR WIFE: deceased

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Fred H. Bauer, 9241 Riverwood Drive — Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b): Arteriosclerosis — 5 yrs

DUE TO (c): 420.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT [ ] **SUICIDE** [ ] **HOMICIDE** [ ]

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 1955, to April 24 1959 and last saw her/him alive on April 23, 1959

Death occurred at 3:55 PM on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: N. J. Honich MD (Degree or title)

22b. ADDRESS: 8902 Riverview Blvd

22c. DATE SIGNED: 4-24-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE: April 27, 1959

23c. NAME OF CEMETERY OR CREMATORY: Bethany Cemetery

23d. LOCATION (City, town, or county) (State): St. Louis County, Missouri

24. FUNERAL DIRECTOR ADDRESS: Math Hermann & Son, Inc., 2161 E. Fair

25. DATE RECD. BY LOCAL REG.: APR 25 '59

26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

(H.T)

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 Clement M. E. Neary

Licensed Embalmer No. 3732

P. O. Address St. Louis

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.