

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-034751

FILED VS SEP 21 1959 317

Registration District No. Primary Registration District No. 500 Registrar's No. 2396

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Koch		Length of stay in 1b 31 days	c. CITY OR TOWN St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Robert Koch Hosp.		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS 1734 S. Huntington Milner Hotel, 18th, Wash.
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Ann Middle (None) Last Bauman			4. DATE OF DEATH Month Sept. Day 7 Year 1959	
--	--	--	---	--

5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10-8-74	9. AGE (last birthday) 84	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
---------------	------------------------	--	--------------------------	---------------------------	--------------------------------	------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) nurse		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Illinois	12. CITIZEN OF WHAT COUNTRY U.S.A.	
--	--	-----------------------------------	--	---------------------------------------	--

13a. FATHER'S NAME Frederick Bauman		13b. MOTHER'S MAIDEN NAME Elsa (Unknown)		14. NAME OF HUSBAND OR WIFE - - -	
--	--	---	--	--------------------------------------	--

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 Address Hospital record room		
--	--	---------------------------------	---	--	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure				INTERVAL BETWEEN ONSET AND DEATH 30 days	
DUE TO (b) Arteriosclerotic heart disease					
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
--	---	--	--	--	--

20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					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 8-6-59 to 9-7-59 and last saw her alive on 9-7-59
Death occurred at 3:25 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Arce R. Brown, M.D.		22b. ADDRESS Robert Koch Hosp.		22c. DATE SIGNED 9-7-59	
---	--	-----------------------------------	--	----------------------------	--

23a. BURIAL, CREMATION, REPOSING Burial	23b. DATE 9/10/59	23c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery	23d. LOCATION (City, town, or county) Chester, Illinois	(State)	
--	----------------------	--	--	---------	--

24. FUNERAL DIRECTOR E. St. Louis, Ill.		25. DATE RECD. BY LOCAL REG. 9-8-59	26. REGISTRAR'S SIGNATURE John C. Murphy, M.D.		
--	--	--	---	--	--

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 Not Embalmed, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed John J. Karry III
Licensed Embalmer No. 5039

P. O. Address E. 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.