

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-007913

FILED VS MAR 8 1960

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 2285**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo</i> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>ST. LOUIS Mo</i>		c. CITY OR TOWN <i>ST. LOUIS</i>	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>2218 INDIANA</i>		d. STREET ADDRESS (If outside, give location) <i>2218 INDIANA</i>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <i>PAULINE E. BAUER</i>			4. DATE OF DEATH Month Day Year <i>FEB. 24 1960</i>		
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>APR. 16 1929</i>	9. AGE (last birthday) <i>30</i>	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) <i>STOCK CLERK</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>CARSON FURNITURE</i>		11. BIRTHPLACE (City, and state or country) <i>Mo</i>	
12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>		13a. FATHER'S NAME <i>PAUL MEYER</i>		13b. MOTHER'S MAIDEN NAME <i>LUCILLE POWERS</i>	
13c. NAME OF HUSBAND OR WIFE <i>KENNETH BAUER</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT Address <i>KENNETH BAUER 2218 INDIANA</i>					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute myocarditis Rheumatoid</i>			INTERVAL BETWEEN ONSET AND DEATH <i>2 month</i>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Rheumatic heart disease</i>			<i>10 yr</i>		
DUE TO (c) <i>mitral insufficiency and</i>			<i>10 yr</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>arteriosclerosis -</i>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown		
410 +					

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 <i>Four a.m.</i>					

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 <i>Feb. 1950</i> to <i>Feb. 24, 1960</i> and last saw him alive on <i>2/24/1960</i> Death occurred at <i>8:45 p.m.</i> on the date stated above, and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE (Degree or title) <i>Dominic J. Verdery</i>		22b. ADDRESS <i>4500 Olive St</i>	22c. DATE SIGNED <i>2-25-60</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE <i>FEB. 27 1960</i>	23c. NAME OF CEMETERY OR CREMATOR <i>NEW ST. MARCUS CEM.</i>	
23d. LOCATION (City, town, or county) (State) <i>ST. LOUIS Mo</i>		24. FUNERAL DIRECTOR ADDRESS <i>Thomas Lutes 2906 Prairie</i>	
25. DATE RECD. BY LOCAL REG. <i>FEB 27 1960</i>		26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF Funeral Home

SP

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Eleana Province

Licensed Embalmer No. 3403

P. O. Address 2906 Grove

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.