

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-033356

FILED VS SEP 12 1960 317

Registration District No. 500 Primary Registration District No. 500 Registrar's No. 2337

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Gardenville		c. CITY OR TOWN St. Louis	
Length of stay in 1b		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Miller Nursing Home		d. STREET ADDRESS (If outside, give location) 3627 Juniata St.	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) Wilhelmine (Minnie) C. Bauer			4. DATE OF DEATH Month August Day 4 Year 1960		
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 1/11/74	9. AGE (last birthday) 86	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housekeeping		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (City and state or country) St. Louis, Missouri	
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME Louis F. Bauer		13b. MOTHER'S MAIDEN NAME Anna Huefner	
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 Marie Kolb - 3627 Juniata St.		Address			

18. CAUSE OF DEATH (Enter only one cause per line for PART I. Death was caused by: IMMEDIATE CAUSE (a) Pneumonia Lobar Hypostatic			INTERVAL BETWEEN ONSET AND DEATH 2 days	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Arteriosclerosis			4 days
	DUE TO (c) Chronic Myocarditis			4 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Blindness due to trachoma & Senility			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	

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"/> none	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 <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 May 5-1958 to August 4, 1960 and last saw her August 3, 1960 and last saw him alive on August 3, 1960 Death occurred at 1:00 P. m on the date stated above, and to the best of my knowledge from the causes stated.				

22a. SIGNATURE [Signature] (Degree or title)		22b. ADDRESS 2767 Gravois Ave. St. Louis, Mo. Aug. 4-60		22c. DATE SIGNED
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Aug. 6, 1960	23c. NAME OF CEMETERY OR CREMATORY New St. Marcus Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri	
24. FUNERAL DIRECTOR WACKER-HELDERLE-3634 Gravois Ave.		25. DATE RECD. BY LOCAL REG. 8-5-60	26. REGISTRAR'S SIGNATURE [Signature]	

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 _____ or by _____ Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *Lawrence M. L.*

Licensed Embalmer No. 4375
P. O. Address St. Louis 23.

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.