

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS OCT 10 1960

-60-036942

IDED

Registration District No. 317 Primary Registration District No. 590 Registrar's No. 2788

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Berleley</u>		Length of stay in 1b		c. CITY OR TOWN <u>Glendale</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>OakKnoll Nursing Home</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>854 Brookside Dr.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>SILTA</u> Middle <u>BAUR</u> Last <u>BAUR</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>20</u> Year <u>1960</u>				
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>9/6/1875</u>		
9. AGE (last birthday) <u>85</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HR Hours <u> </u> Min. <u> </u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>			11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>		
12. CITIZEN OF WHAT COUNTRY <u>USA</u>								
13a. FATHER'S NAME <u>Ernest G. Hofmann</u>				13b. MOTHER'S MAIDEN NAME <u>Clara Steinwender</u>		14. NAME OF HUSBAND OR WIFE <u>Harry L. Baur</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>H. Nulsen Baur</u> Address <u>854 Brookside Dr. Glendale</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart disease</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Parkinsons Syndrome, Dementia, organic</u> 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"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)				
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u>		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 <u> </u> STATE <u> </u>		
21. I attended the deceased from <u>Dec 6, 1955</u> to <u>Sept 20, 1960</u> and last saw her alive on <u>9/14/60</u> Death occurred at <u>6:35 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>Lewis Lillmann</u> (Degree or title) <u>M.D.</u>				22b. ADDRESS <u>8231 Clayton Rd (17)</u>		22c. DATE SIGNED <u>9/20/60</u> (State)		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>9/20/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Beldefontaine Cemetery</u>		23d. LOCATION (City, town, or county) <u>St. Louis Missouri</u>		
24. FUNERAL DIRECTOR <u>C.R. Lupton and sons</u> ADDRESS <u>7233 Delmar Blvd</u>				25. DATE RECD. BY LOCAL REG. <u>9-20-60</u>		26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>		

(Licensed Embalmer's Statement on Reverse Side)

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

Student _____
Signature of Student Embalmer

Signed Clarence A. Mu

Licensed Embalmer No. 401

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to
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.