

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

MAY 13 1935

14725

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City.....

No. **4243**

Magalloway

Ward

File No.....

Registered No. **3562**

St.

Ward

2. FULL NAME

(a) Residence, No. **4243**

(Usual place of abode)

Magalloway St. **3**

Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

A. Baedeker

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

March 17 - 1861

7. AGE

YEARS *74*

MONTHS *1*

DAYS *1*

If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

None

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Germany

FATHER

13. NAME

Wachold

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Germany

MOTHER

15. MAIDEN NAME

Schmidt

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Germany

17. INFORMANT (ADDRESS)

Mrs. Baedeker 4243 Magalloway

18. BURIAL, CREMATION, OR REMOVAL

PLACE

St. John's

DATE

Apr 22 1935

19. UNDERTAKER (ADDRESS)

H. J. Neff 3125 S. Olive

20. FILED

APR 20 1935

J. H. Baedeker Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR)

Apr 18 1935

22. I HEREBY CERTIFY, That I attended deceased from

Jan 15 - 1935 to Apr 18 - 1935

I last saw him alive on *4 - 18 - 1935* Death is said

to have occurred on the date stated above, at *11:20 A.M.*

The principal cause of death and related causes of importance were as follows:

Chronic Parenchymatous nephritis

Other contributory causes of importance:

Chronic myocarditis

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide?..... Date of injury....., 19.....

Where did injury occur?..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....

If so, specify.....

(Signed) *E. J. Klaepfel*, M. D.

(Address) *905 Morrison Ave.*

