

REGISTRATION DISTRICT NO. **791**
1008

Primary Registration District No. _____ Registrar's No. **6850**

1. PLACE OF DEATH:
(a) County _____
(b) City or town **St. Louis**
(c) Name of hospital or institution: **Lutheran Hospital**
(d) Length of stay: In hospital or institution **2 weeks**
In this community **44 years**

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County _____
(c) City or town **St. Louis, Missouri**
(d) Street No. **3555 Sidney Street**
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME **MRS. MABEL BAKER**
(b) If veteran, name war _____ (c) Social Security No. **260**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **August** day **4th**
year **1939** hour **2** minute **10** A. M.

4. Sex **Female** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Dr. C. H. Baker**
6. (c) Age of husband or wife if alive **52** years
7. Birth date of deceased **July 4, 1895**

21. I hereby certify that I attended the deceased from **8-27-39** to **8/4/39**
that I last saw her alive on **8-4** and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	44	1	-	hr. _____ min. _____

Immediate cause of death
pneumonitis acute

9. Birthplace **St. Louis Missouri**
10. Usual occupation **Household**

Due to _____
Due to _____

11. Industry or business _____
12. Name **Dr. Robert E. Graul**
18. Birthplace **Burton Texas**
14. Maiden name **Theresa Bartens**
15. Birthplace **Belleview Illinois**

Other conditions **Septicemia caused by bacterial endocarditis**
Major findings of operations _____
Of autopsy **NO**

16. (a) Informant's own signature **Mrs. C. A. Baker**
(b) Address **3555 Sidney**

Underline the cause to which death should be charged statistically.
PHYSICIAN _____

17. (a) **Burial** (b) Date thereof **Aug. 7, 1939**
(c) Place: burial or cremation **New St. Marcus Cemetery**
18. (a) Signature of funeral director **Pauline's Funeral Home**
(b) Address **1936 St. Louis Avenue**
19. (a) **AUG 7 1939** (b) **J. J. Friedrich**

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature **Wm. B. Karent** (M. D. or other) _____
Address **600 S. Kingshighway** Date signed **8-5-39**

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.

MAY 2 1945

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed

Delia C. Krupin

Licensed Embalmer No.

3497

P. O. Address

1936 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 this body is not embalmed, above space should be left blank.