

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

30188

State File No. \_\_\_\_\_

Registration District No. 784

Primary Registration District No. 200

Registrar's No. 1409

1. PLACE OF DEATH:  
 (a) County St. Louis.  
 (b) City or town Lamay  
 (c) Name of hospital or institution: Mount St. Rose Hospital.  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 6 Mo 12 days.  
 (Specify whether  
 In this community 35 Years  
 years, months or days)

3. (a) PRINT FULL NAME Clarence W. Bahn.  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. 493-01-371

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
 6. (b) Name of husband or wife Mary Quigley Bahn/ 6. (c) Age of husband or wife if alive 48 years  
 7. Birth date of deceased Feb. 20 1889  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
50 5 16 hr. min.

9. Birthplace Cincinnati, Ohio  
 (City, town, or county) (State or foreign country)

10. Usual occupation Optician.

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
 { 12. Name William Bahn.  
 { 13. Birthplace Cincinnati, Ohio.  
 (City, town, or county) (State or foreign country)  
 { 14. Maiden name Anna Johnson.  
 { 15. Birthplace Cincinnati, Ohio.  
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mary Bahn  
 (b) Address 7344 Dale Ave

17. (a) Burial (b) Date thereof Aug. 8, 1939  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Calvary Cemetery.

18. (a) Signature of funeral director Arthur J. Donnelly  
 (b) Address 3840 Lindell Blvd  
 19. (a) AUG 7 1939 (b) Th. Meyer M.D.  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Mo. (b) County St. Louis  
 (c) City or town Richmond Heights, Mo.  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 7344 Dale Ave.  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month August day 6 11  
 year 1939 hour 8 P minute 35 AM.  
 21. I hereby certify that I attended the deceased from July 1st  
1939, 19   to August 6, 1939  
 that I last saw him alive on August 5, 1939  
 and that death occurred on the date and hour stated above.

Immediate cause of death Fae Adv bilat Pulm tuberculosis & cerebral  
 Due to \_\_\_\_\_  
 Due to 23 in  
 Other conditions Sube cerebral Entenb  
 (Include pregnancy within 3 months of death)

PHYSICIAN  
 Major findings: \_\_\_\_\_  
 Of operations \_\_\_\_\_  
 Of autopsy Fae Adv bil Pulm tuberculosis & cerebral  
 Underline the cause to which death is charged as immediate

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? \_\_\_\_\_ (City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?  
 \_\_\_\_\_ (Specify type of place)  
 While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature R. C. Bauman (M. D. or other)  
 Address 9101 So Broadway Date signed 8-6-39

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

**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 Stanley Marshall

Licensed Embalmer No. 2868

P. O. Address 3840 Linden

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

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