

WHITE PLAIN—USE UNFADING BLACK INK—MAKE 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 31161

Registration District No. 1003

Primary Registration District No. _____

Registrar's No. 8224

1. PLACE OF DEATH:

(a) County City of St. Louis /
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: DePaul Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County ST LOUIS /
(c) City or town UNIVERSITY CITY
(If outside city or town limits, write "RURAL")
(d) Street No. 7238 FORSYTHE NR
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME

Ida Anna Baiter 791

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife William J. Baiter

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Jan 17 1870
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
69 8 7 M hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER { 12. Name Peter Grebil

13. Birthplace Germany
(City, town, or county) (State or foreign country)

14. Maiden name Anna Siegmund

15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Clarence A Baiter

(b) Address 3412 Clifton Ave Cinn. Ohio

17. (a) removal (b) Date thereof 9-25-39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cincinnati, Ohio

18. (a) Signature of funeral director ALBERT H. HOPPE INC

(b) Address 4700 W. Washington

19. (a) SEP 25 1939
(Date received local registrar)

(b) J. F. Budick
(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 24 day September
year 39 hour 11 P minute _____ M.

21. I hereby certify that I attended the deceased from 5-13- 1939 to 9-24- 1939
that I last saw him alive on 9-24- 1939
and that death occurred on the date and hour stated above.

Immediate cause of death

Pulmonary Pneumonia (Rt. Lower Lobe) Duration 9-18-39

Due to _____
Due to _____

Other conditions Chc. Nephritis 1925
Chc. Myocarditis 1930
(Include pregnancy within 3 months of death) PHYSICIAN

Major findings: Of operations none

Of autopsy none
Underline the cause to which death should be charged statistically.

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? ✓

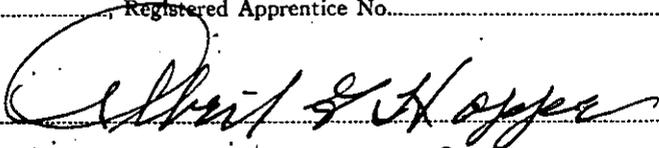
While at work? _____ (Specify type of place) (e) Means of injury ✓

23. Signature Roy Johnson (M. D. or other)
Address Ferguson Mo Date signed 9-25-39

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 .....

Licensed Embalmer No. 2971.....

P.O. Address.....

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.