

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

37205
Do not use this space.

NOV 9 1939

1. PLACE OF DEATH

(a) County St. Louis Registration District No. 784

(b) Township _____ Primary Registration District No. 111

(c) City Richmond Heights (d) Street No. St. Marys Hospital St. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)

(e) Length of residence in city or town where death occurred
yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME William Baer

(a) Residence, No. 6151 Waterman Ave St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male	4. COLOR OR RACE White	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Joy Baer		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 5/5/1915		
7. AGE YEARS 24	MONTHS 5	DAYS 10
If LESS than 1 day, _____ hrs. or _____ min.		
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Clerk	
	9. Industry or business in which work was done, as saw mill, bank, etc. Woolworth Co	
	10. Date deceased last worked at this occupation (month and year) _____	
FATHER	11. Total time (years) spent in this occupation _____	
	12. BIRTHPLACE (CITY OR TOWN) St. Louis (STATE OR COUNTRY) Mo	
MOTHER	13. NAME William Baer	
	14. BIRTHPLACE (CITY OR TOWN) St. Louis (STATE OR COUNTRY) Mo	
	15. MAIDEN NAME Breta Sprengmann	
16. BIRTHPLACE (CITY OR TOWN) Hanover (STATE OR COUNTRY) Germany		
17. INFORMANT Mrs. Joy Baer (ADDRESS) 6151 Waterman Ave		
18. BURIAL, CREMATION, OR REMOVAL PLACE OAK GROVE DATE 10/17/39		
19. FUNERAL DIRECTOR (NAME) Robert J. Ambruster (ADDRESS) Clayton Rd At Concordia Lane		
20. FILED OCT 17 1939 D. R. Meyer Local Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **10/15/39**, 19

22. I HEREBY CERTIFY, That I attended deceased from **10/9**, 19**39**, to **10/15/39**, 19

I last saw h. him alive on **10/15/39**, 19. Death is said to have occurred on the date stated above, at **8.30A.m.**

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

Myocardial failure
Intestinal obstruction
Complete

Date of onset **10-14-39**
10-11-39

Other contributory causes of importance:

Name of operation **yes** Date of **10-14-39**
What test confirmed diagnosis? **operation** Was there an autopsy? **yes**

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) **Fred Kramer**, M. D.
(Address) **634 N. Grand Blvd**

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.

I X18605

1022
JAN 7 1948

JAN 22 1948

JAN 27 1948

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.....

.....**Edward H. Bockhorst**....., Registered Apprentice No.....
working under my personal supervision.

Signed *Edward H. Bockhorst*

Licensed Embalmer No. **2502**.....

P. O. Address **Clayton Mo.**.....

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.

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CERTIFICATE OF DEATH**

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1. PLACE OF DEATH

County St. Louis Registration District No. 784 File No. 37205
 Township Rich. Hts. Primary Registration District No. 114 Registered No. 1921
 City Rich. Hts. (No. St. Marys Hosp) - St. _____ Ward _____

2. FULL NAME

William Baer
 (a) Residence, No. _____ St. _____ Ward _____
 (Usual place of abode) (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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) M

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
24 5 10

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____
 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 long years spent in this occupation _____

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

13. NAME

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

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____ 19____

19. UNDERTAKER (ADDRESS)

20. FILED _____ 19____

Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct. 15, 1924

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

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

Myocardial Failure Date of onset _____
Intestinal Obstruction
Adhesions from chronic peritonitis 10-11-24

Other contributory causes of importance: 226

Name of operator Yes - Intestinal Obst. Date of 10-29-24

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 Fred Kramer, M. D.

(Address) 634 N. Grand

(over)

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.

EXEMPTORY

Patient had a complete
obstruction of terminal ileum
from adhesions binding multiple loops
of intestine to one another - causing
a solid mass of intestines in the
right lower quadrant of abd.

Laparotomy + ileostomy was
done.

Patient expired with shock
and myocardial infarct 24 hours
after operation.

Ed. Keenan