

Registration District No. 198

Primary Registration District No. 3011

24
2
1

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Clay

(b) City or town Excelsior Springs
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Excelsior Springs Sanitarium
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 13 days
(Specify whether years, months or days)

In this community 13 days
(Specify whether years, months or days)

3. (a) PRINT FULL NAME LENA BAIER 600

3. (b) If veteran, name war no 3. (c) Social Security No. no

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife none 6. (c) Age of husband or wife if alive no years

7. Birth date of deceased, Jan 6, 1871
(Month) (Day) (Year)

8. AGE: Years 69 Months 7 Days 21 If less than one day hr. min.

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

10. Usual occupation Housemaid

11. Industry or business

MOTHER FATHER

12. Name Chris Baier

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

14. Maiden name Katherine Arnold

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

16. (a) Informant Mrs Claus Wilson

(b) Address Wcata, Iowa

17. (a) Removal (b) Date thereof 8/27/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Adair, Iowa

18. (a) Signature of funeral director Herbert Hoyle

(b) Address Excelsior Springs

19. (a) Aug 31, 1940 (b) Mrs Pess McCracken
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State IOWA (b) County CASS

(c) City or town Excelsior Springs
(If outside city or town limits, write "RURAL")

(d) Street No. Excelsior Springs
(If rural, give location)

(e) If foreign born, how long in U. S. A. 58 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day Twenty year 1940 hour 12 minute 45 A.M.

21. I hereby certify that I attended the deceased from Aug 26 1940 to Aug 27 1940 that I last saw her alive on Aug 27 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Edema Duration 36 hours

Due to Very weak heart + Low Blood Pressure

Due to Chronic Multiple Myelitis

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations none Of autopsy none

PHYSICIAN 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? 180 (Specify type of place) (e) Means of injury ✓

23. Signature John T. Grace (M. D. or other) MD Address Excelsior Springs Date signed 8/27/40

4-9-110
District File Number
District Health Officer No. 8
RECEIVED

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 Virgil Hope
Licensed Embalmer No. 3950
P. O. Address Excelsior Springs

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **28277**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **198**

Primary Registration District No. **3011**

Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County **Clay**
(b) City or town **Carroll Springs**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(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)

3. (a) PRINT FULL NAME **Lena Baier**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **S**

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

7. Birth date of deceased **Jan 6 1876**
(Month) (Day) (Year)

8. AGE: Years **69** Months **6** Days **21** If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) **Oct 5-1940** (b) **Mrs. R. W. Cracker**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug** day **27**
year **1940** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

Duration

PHYSICIAN

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 _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

