

No. 2
4-13-40
5-17-39
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FILED APR 21 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **9434**
2844
Registrar's No.

Registration District No. **791** Primary Registration District No. **1003**

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

1. PLACE OF DEATH:
(a) County.....
(b) City or town **St Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
BARNES HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **18 days**
Specify whether
In this community.....
years, months or days

3. (a) PRINT FULL NAME **August Bayer**
(b) If veteran, name war **No**
(c) Social Security No. **493-07-3629**

4. Sex **Male** 5. Color or race **White**
6. (a) Single, widowed, married, divorced, **Single**
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased **April 9 1884**
(Month) (Day) (Year)

8. AGE: Years **56** Months **11** Days **22**
If less than one day
hr. min.

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

10. Usual occupation **Shipping Clerk**

11. Industry or business **Bayer Machine Co**

MOTHER FATHER
12. Name **Frank X. Bayer**
13. Birthplace **Germany**
(City, town, or county) (State or foreign country)
14. Maiden name **Anna Wind**
15. Birthplace **Germany**
(City, town, or county) (State or foreign country)

16. (a) Informant **Frank Bayer**
(b) Address **3853 Cleveland Ave**

17. (a) **Burial**
(Burial, cremation, or removal) (b) Date thereof **April 1 1941**
(Month) (Day) (Year)

(c) Place: burial or cremation **St. Peter and Paul Cemetery**

18. (a) Signature of funeral director **Peetz Brothers**
3029 Lafayette Ave
(b) Address

19. **MAR 31 1941** (Date received local Registrar)
J. T. Bredich (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County.....
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **3853 Cleveland Ave**
(If rural, give location)
(e) If foreign born, how long in U. S. A.? **0** years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **March** day **29**
year **1941** hour **5** minute **35** M.

21. I hereby certify that I attended the deceased from **3-11-41**
....., 19....., to **3-29**, 19.....
that I last saw him alive on **3-29**, 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death **Post operative Thoracotomy for Bronchiogenic Carcinoma** Duration
ly?

Due to.....
Due to.....
Other conditions (Include pregnancy within 3 months of death)
H/O

Major findings: Of operations **Bronchiogenic Carcinoma - Inoperable**
Of autopsy.....
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) (c) Means of injury.....
23. Signature **Russell Cider** (M. D. or other)
Address **BARNES HOSPITAL** Date signed **3/29/41**

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.....
Frank J. Owen

Licensed Embalmer No. *2245*

P. O. Address.....
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, fact should be so stated above.