

Registration District No. _____ Primary Registration District No. **1003**

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

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1. PLACE OF DEATH:

(a) County _____

(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Louis City Hospital-Max C. Starkloff
(If not in hospital or institution, write street number or location) Memorial

(d) Length of stay: In hospital or institution 29 days
(Specify whether _____)

In this community _____
years, months or days)

3. (a) PRINT FULL NAME JOSEPH BAUMRUCKER

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

4. Sex Male **5. Color or** White **6. (a) Single, widowed, married,** Divorced
race _____ divorced _____

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

7. Birth date of deceased. March 10 1884
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>61</u>	<u>6</u>	<u>21</u>	_____ hr. _____ min.

9. Birthplace: Evansville Indiana
(City, town, or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business _____

12. Name Paul Baumrucker

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

14. Maiden name Unknown

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

16. (a) Informant Mary Sink

(b) Address 906a Lami St.

17. (a) Burial **(b) Date thereof** Oct. 4, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Concordia Cemetery

18. (a) Signature of funeral director Wacker Elderle

(b) Address 2624 N. Davis

19. (a) OCT 3 1945 **(b)** J. F. Bredeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

(c) City or town St. Louis 172-3
(If outside city or town limits, write "RURAL")

(d) Street No. 2224 Rear So. Broadway
(If rural, give location)

(e) Citizen of foreign country? 1 (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 1st
year 1945 hour 7:15 minute _____ P. _____ M.

21. I hereby certify that I attended the deceased from 9/2/45
3, 19____, to 10/1/45, 19____;
that I last saw h. im alive on 10/1/45, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial failure **Duration** _____

Due to Hypertensive Cardiovascular Disease

Due to _____

Other conditions Pleural effusion of
(Include pregnancy within 3 months of death) cytic - Catarrhal

Major findings: _____ **PHYSICIAN** _____
Of operations _____ Underline the cause to which death should be charged statistically.

Of autopsy 93

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) _____
(g) Means of injury _____

23. Signature W. H. Hamilton **(M. D. or other)** MD
1515 Lafayette 10/2/45
Address Date signed

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.....

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, fact should be so stated above.