

U.S. No. 2
FORM-5-43
Rev. 5-17-39
I X38671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 5 1946

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 0
Registrar's No. 2955

Registration District No. 317

Primary Registration District No. 3069

1. PLACE OF DEATH:
 (a) County St. Louis County
 (b) City or town Richmond Heights
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: St. Mary's Hospital 0
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution one week
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County St. Louis 96
 (c) City or town Overlands, Mo.
(If outside city or town limits, write "RURAL")
 (d) Street No. 2325 Brown Road
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Bernard Wm. Baumann
 3. (b) If veteran, name war World War 1
 3. (c) Social Security No. 488-07-1536

4. Sex Male 5. Color or race W
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Mabel Gill
 6. (c) Age of husband or wife if alive 48 years
 7. Birth date of deceased Feb. 17, 1894
(Month) (Day) (Year)

8. AGE: Years 51 Months 10 Days 6
 If less than one day _____ hr. _____ min.

9. Birthplace St. Genevieve, Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Printer

11. Industry or business _____

12. Name Chas. Baumann
13. Birthplace St. Genevieve Mo
(City, town, or county) (State or foreign country)

14. Maiden name Magdalene Roth
15. Birthplace St. Genevieve, Mo. 0
(City, town, or county) (State or foreign country)

16. (a) Informant Mabel Baumann
(b) Address 2325 Brown Road

17. (a) Burial (b) Date thereof Dec. 20, 45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director _____
(b) Address 4746 West Florissant

19. (a) 12-29-45 (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 23
 year 1945 hour 10 minute 20 A.M.
21. I hereby certify that I attended the deceased from Dec 17
1945 to Dec 23 1945
 and that death occurred on the date and hour stated above.

Immediate cause of death Cardio Cerebral Vascular Disease
 Duration ?
 Due to 1310
 Due to _____
 Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
 Of operations _____
 Of autopsy Cardio Cerebral Vascular Disease
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? _____

23. Signature H. H. Thomas (M. D. or other) _____
Address 2325 Brown Road
Date signed 12/26/45

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

6
8
3

JAN 14 1946

JAN 10 1946

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..... *W. Wilkins*

Licensed Embalmer No. *3575*

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.