

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 7340

FILED MAR 6 1947

Registration District No. 17

Primary Registration District No. 6076

Registrar's No. 414

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town St. Louis, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Miller Nursing Home 4  
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 000  
(c) City or town St. Louis 17  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2717 1/2 McNair St. 9  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Christ Bauer

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

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

6. (b) Name of husband or wife Amelia Bauer 6. (c) Age of husband or wife if alive 76 years

7. Birth date of deceased Sept. 9 1868  
(Month) (Day) (Year)

8. AGE: Years 88 Months 5 Days 15 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Germany 7  
(City, town, or county) (State or foreign country)

10. Usual occupation Beer Brewer Retired

11. Industry or business \_\_\_\_\_

12. Name Unkn. Bauer 4

13. Birthplace Germany (State or foreign country)

14. Maiden name Unkn. 4

15. Birthplace Germany (State or foreign country)

16. (a) Informant Amelia Bauer

(b) Address 2717 1/2 McNair St.

17. (a) Burial (b) Date thereof 2-27-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Marcus Cem.

18. (a) Signature of funeral director Wm. Bro. L. V. No.

(b) Address 2929 S. Jefferson Av.

19. (a) 2-27-47 (b) Ruth L. Allen, M.D.  
(Date received local registrar) (Registrar's signature) ac

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 24  
year 1947 hour 7 minute 00 p. M.

21. I hereby certify that I attended the deceased from Dec. 4th, 1946 to Feb. 24th 47  
that I last saw h. im. alive on Feb. 23rd, 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Myocarditis Duration 4 days

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Chronic Arterio-Sclerosis  
(Include progress within 3 months of death) and chronic bronchitis 2 mo.

Major findings: Of operations no PHYSICIAN \_\_\_\_\_

Of autopsy no 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 0

23. Signature Dr. W. H. Walters (M. D. XXXX)  
Address 3608 S. Grand Blvd. Date signed 2/25/47

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

6  
0  
9

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**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. 3741

P. O. Address 2929 1/2 Persimmon

**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.**