

S. No. 2
DM-5-43
v. 5-17-39
P 1 X36671

State File No. 10528
Registrar's No. 2674

FILED MAR 31 1947
Registration District No. 518

Primary Registration District No. 1003

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

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution: Deaconess Hospital
(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 John H. Bauer

3. (b) If veteran, name war War I

3. (c) Social Security No. 714-05-8988

4. Sex M **5. Color or race** W

6. (a) Single, widowed, married, divorced S. O

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

7. Birth date of deceased October 25, 1885
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>61</u>	<u>4</u>	<u>14</u>	hr. _____ min.

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

10. Usual occupation R.R. Representative

11. Industry or business

MOTHER FATHER

12. Name J. Karl Bauer

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

14. Maiden name Rose Uhlman

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

16. (a) Informant Miss Bauer, sister

(b) Address Cincinnati, Ohio

17. (a) Burial, cremation, or removal burial **(b) Date thereof** 3-13-47
(Month) (Day) (Year)

(c) Place: burial or cremation Cincinnati, Ohio

18. (a) Signature of funeral director Harrigan & Sheahan

(b) Address 4415 Washington, Bl.

19. (a) Date received local registrar MAR 13 1947 **(b) Registrar's signature** J. F. Budick

2. USUAL RESIDENCE OF DECEASED:

(a) State Ohio (b) County Warren

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

(d) Street No. 2732 Massachusetts Ave.
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March 13
year 1947 hour 3 minute a 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 Subdural Hematoma

Due to Time, Place, Cause

Due to and manner of death

Other conditions could not be determined
(Include pregnancy within 3 months of death)

Duration

PHYSICIAN

Major findings: Of operations _____

Of autopsy 1959

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) gentle contact

(b) Date of occurrence 1-15-47 February 15, 1947

(c) Where did injury occur? 1800 Clark
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, industrial place, in public place?
Undetermined

White at work? Yes

23. Signature Patrick E. Taylor **(M.D. or other)** Sup 3

Address 1300 Clark **Date signed** 4-13-47

MAY 12 1947

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

Henry M. Brammer

Licensed Embalmer No.

4200

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.