

No. 300  
10-47  
5-17-39  
1-2908

FILED APR 30 1948  
Registration District No. 317

Primary Registration District No. 3063

1. PLACE OF DEATH:

(a) County St. Louis County

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

(c) Name of hospital or institution:  
ST. LOUIS COUNTY HOSPITAL  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8 HRS.  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County St. Louis Co.

(c) City or town RICHMOND HEIGHTS 91  
(If outside city or town limits, write "RURAL")

(d) Street No. 1404 B WOODLAND  
(If rural, give location)

(e) Citizen of foreign country? 3 (Yes or No)  
If yes, name country \_\_\_\_\_

3: (a) PRINT FULL NAME CATHERINE ALICE BAKER

3. (b) If veteran, name war None 3. (c) Social Security No. \_\_\_\_\_

4. Sex FEMALE 5. Color or race WHITE

6. (a) Single, widowed, married, divorced WIDOWED

6. (b) Name of husband or wife EARNEST L. BAKER 6. (c) Age of husband or wife if alive \_\_\_\_\_ year

7. Birth date of deceased JAN 23 1894  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

56 9 21 hr. \_\_\_\_\_ min.

9. Birthplace MORPHYSBORO ILL.  
(City, town, or county) (State or foreign country)

10. Usual occupation NONE

11. Industry or business NONE

12. Name HENRY WEBER 4

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

14. Maiden name ROSENA SCHENK

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

16. (a) Informant W. L. BAKER

(b) Address 409 THOMAS, FERGUSON

17. (a) Removal (b) Date thereof 4/26/48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation urphysboro, Illinois

18. (a) Signature of funeral director Math Hormenn & Son, Inc.

(b) Address 2161 East Fair Ave

19. (a) 4-26-48 (b) Catherine Baker  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month APRIL day 24  
year 1948 hour 2 minute 40 AM.

21. I hereby certify that I attended the deceased from APRIL 23, 1948, to APRIL 24, 1948; and that death occurred on the date and hour stated above.

that I last saw h. ER alive on APRIL 24, 1948

Immediate cause of death possible  
barbiturate poisoning.

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

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

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

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 APRIL 23, 1948 / 27

(c) Where did injury occur? RICHMOND HEIGHTS, ST. LOUIS CO.  
(City or town) (County) (State) MO.

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

While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury TOOK SLEEPING PILLS

23. Signature William Brown (M. D. or other) \_\_\_\_\_

Address 601 BRENTWOOD BLVD Date signed 4/24/48

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

MAY 12 1934

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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 *William G. Buchholz*

Licensed Embalmer No. *2110*

P. O. Address. *St. Louis, Mo.*

**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.**

Registration District No. 317 Primary Registration District No. 3063

1. PLACE OF DEATH:

(a) County 34 Lewis County  
(b) City or town Clayton  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: St. Louis Co. 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 \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Catherine A Baker

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

4. Sex F 5. Color or race w 6. (a) Single, widowed, married wid

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased July (Month) 24 (Day) 1924 (Year)

8. AGE: Years 56 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation \_\_\_\_\_

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

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July Day 24 Year 1980 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 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 \_\_\_\_\_

Duration 24-48 hr

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

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

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy suicide

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) Suicide

(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 \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

MOTHER FATHER

SUPPLEMENTAL

S-14832