

FILED AUG 5 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

245884

State File No. ....

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| BIRTH NO. <u>44204-49</u>   |  | REG. DIST. NO. _____   |  | PRIMARY REG. DIST. NO. _____  |  | Registrar's No. <u>10029</u>   |  |
| 1. PLACE OF DEATH<br>a. COUNTY _____  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission).<br>a. STATE <u>Mo</u> b. COUNTY <u>St. Louis</u> |  |  |  |
| b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>St. Louis</u> )   |  | c. LENGTH OF STAY (in this place) (township) <u>1 1/4 hrs.</u>   |  | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kimmswick</u>   |  | d. STREET ADDRESS (If rural, give location) <u>M.R.</u>                          |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Evangelical Deaconess Hosp.</u>  |  |  |  | 3. NAME OF DECEASED (Type or Print) a. (First) <u>Baby</u> b. (Middle) <u>Baum</u> c. (Last) _____                                      |  |  |  |
| 4. DATE OF DEATH (Month) (Day) (Year) <u>6 - 28 - 49</u>  |  | 5. SEX <u>M. U</u>   |  | 6. COLOR OR RACE <u>Wh</u>  |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>17</u>                 |  |
| 8. DATE OF BIRTH <u>6-28-49</u>   |  | 9. AGE (In years last birthday) _____  |  | IF UNDER 1 YEAR Months _____ Days _____   |  | IF UNDER 6 HRS. Hours _____ Mins. <u>45</u>                                      |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____   |  | 10b. KIND OF BUSINESS OR INDUSTRY _____  |  | 11. BIRTHPLACE (State or foreign country) <u>Missouri</u>   |  | 12. CITIZEN OF WHAT COUNTRY? _____   |  |
| 13a. FATHER'S NAME <u>Walter Baum</u>   |  | 13b. MOTHER'S MAIDEN NAME <u>Rudrey Buechting</u>  |  | 14. NAME OF HUSBAND OR WIFE _____   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____   |  | 16. SOCIAL SECURITY NO. _____  |  | 17. INFORMANT'S SIGNATURE OR NAME <u>Walter Baum</u>  |  | ADDRESS <u>Kimmswick, Mo</u>   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) _____  |  | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Anencephalic monster</u>   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH _____   |  |
| *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.  |  | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ |  |   |  |  |  |
|   |  | II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Spina Bifida</u> |  |   |  |  |  |
| 19a. DATE OF OPERATION <u>none</u>  |  | 19b. MAJOR FINDINGS OF OPERATION _____   |  |   |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>none</u>  |  | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____   |  | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) _____ (STATE) <u>157 m</u>  |  |  |  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____   |  | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21f. HOW DID INJURY OCCUR? <u>750X</u>  |  |  |  |
| 22. I hereby certify that I attended the deceased from <u>6/28</u> , 19 <u>49</u> , to <u>6/28</u> , 19 <u>49</u> that I last saw the deceased alive on <u>6/28</u> , 19 <u>49</u> and that death occurred at <u>1:00 P. m.</u> , from the causes and on the date stated above. |  |  |  |   |  |  |  |
| 23a. SIGNATURE (Degree or title) <u>Rudley R. Smith</u>   |  |  |  | 23b. ADDRESS <u>Missouri Theatre Bldg</u>   |  | 23c. DATE SIGNED <u>6/29/49</u>  |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) _____   |  | 24b. DATE <u>JUL 31 1949</u>   |  | 24c. NAME OF CEMETERY OR CREMATORY <u>Anatomical Days</u>   |  | 24d. LOCATION (City, town, or county) (State) _____                              |  |
| DATE REC'D BY LOCAL REG. <u>JUL 31 1949</u>   |  | REGISTRAR'S SIGNATURE <u>J. B. Foster</u>  |  | 25. FUNERAL DIRECTOR'S NAME <u>Rowland Mortuary Service</u><br>Address <u>1104 Manchester Ave.</u>                                      |  |  |  |

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

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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.....

..... Student Embalmer No. ....

working under my personal supervision.

Signed.....

Signed.....  
Student Embalmer

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.