

FILED MAR 1 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 5610

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 256 PRIMARY REG. DIST. NO. 5879 Registrar's No. 1

1. PLACE OF DEATH a. COUNTY <u>Craig Co Rural, Mo</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Chambers, Mo</u> COUNTY <u>Craig Co</u>	
b. CITY (If outside corporate limits, write RURAL and give town or township) <u>Chambers, Mo Rural</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Chambers, Rural</u>	
c. LENGTH OF STAY (in this place) <u>25 days</u>		d. STREET ADDRESS (If rural, give location) _____	
d. FULL NAME OF HOSPITAL OR INSTITUTION _____			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Casper</u> b. (Middle) _____ c. (Last) <u>Bauer</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Feb 8 1950</u>		
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) <u>Divorced</u>	
8. DATE OF BIRTH <u>Jun-19-1883</u>		9. AGE (In years last birthday) <u>66</u>		10. IF UNDER 1 YEAR: Months <u>5</u> Days <u>1</u> Hours <u>3</u> Mins. <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Labor</u>		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					

13a. FATHER'S NAME <u>John B Bauer</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah Curries</u>		14. NAME OF HUSBAND OR WIFE _____	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. <u>543-20-1926</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Wm Bauer</u> ADDRESS <u>Chambers, Mo</u>	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral hemorrhage</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertension</u> DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>  <u>321X</u>	
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19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____	

22. I hereby certify that I attended the deceased from Sept, 1948, to Feb, 1950, that I last saw the deceased alive on Feb 7, 1950, and that death occurred at 3:30 AM, from the causes and on the date stated above.

23a. SIGNATURE (Degree of title) <u>L. E. Giffen D.O.</u>		23b. ADDRESS <u>Chambers, Mo</u>		23c. DATE SIGNED <u>2/9/50</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		24b. DATE <u>2-10-50</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Deer Creek Cemetery</u>	
		24d. LOCATION (City, town, or county) (State) <u>Chambers, Mo</u>			

DATE REC'D BY LOCAL REG. <u>2-9-1950</u>		REGISTRAR'S SIGNATURE <u>Eather Souder</u> 234		25. FUNERAL DIRECTOR'S SIGNATURE <u>Otto T Stockmuck</u> ADDRESS <u>Chambers, Mo</u>	
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PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

760  
1

RECEIVED FEB 20 1950  
District Health Officer No. 9,  
District File Number.

FEB 27 1950

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.

Student .....  
Student Embalmer

Signed Otto T. Stocksick

Licensed Embalmer No. 1902

P. O. Address Chamois, 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.