

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **6218**  
Registrar's No. **1052**

FILED FEB 27 1952

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis, Missouri</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b> <b>2019</b>	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) <b>515 Bowen</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. John's Hospital</b>			

3. NAME OF DECEASED (Type or Print) a. (First) <b>William N. Bauer</b> b. (Middle) c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) <b>Feb. 1, 1952</b>
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5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>June 29, 1894</b>	9. AGE (In years last birthday) <b>57</b>	10. IF UNDER 1 YEAR Months	11. IF UNDER 2 HRS. Hours	12. IF UNDER 15 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>St. Louis, Mo.</b>	12. CITIZEN OF WHAT COUNTRY?
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13a. FATHER'S NAME <b>Bauer</b>	13b. MOTHER'S MAIDEN NAME <b>Sophia Busch</b>	14. NAME OF HUSBAND OR WIFE <b>Florence Bauer</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes, give year or dates of service) <b>World War I</b>	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Florence Bauer</b>	ADDRESS <b>515 Bowen</b>
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Acute Myocardial Infarction</b>		
	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.			

19a. DATE OF OPERATION <b>None</b>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>no</b>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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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? <b>H201</b>
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22. I hereby certify that I attended the deceased from **Jan 30, 1952**, to **Feb. 1, 1952**, that I last saw the deceased alive on **Feb. 1, 1952**, and that death occurred at **130p m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>Bernard T. Kon</b>	COON (Degree or title)	23b. ADDRESS <b>4755 Maryland Rd. St. Louis 16 Mo.</b>	23c. DATE SIGNED <b>2/2/52</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>2-4-52</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Lakewood Park Cem.</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis County, Mo.</b>
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DATE REC'D BY LOCAL REG. <b>FEB 4 1952</b>	REGISTRAR'S SIGNATURE <b>Carl Smith, MD</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Southern Funeral Home</b>	ADDRESS <b>6322 S. Grand Blvd.</b>
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(Licensed Embalmer's Statement on Reverse Side)

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

Dr. Bernard T. Koon  
4755a Morganford  
Hu. 3434

1 til 4 p.m.

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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.

Student .....  
Student Embalmer

Signed

*David Van Fossan*

Licensed Embalmer No. *42420/Bea*

P. O. Address *6522 So Grand*

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.