

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **8492**
1266

BIRTH NO. **FILED APR 7 1954** REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002** Registrar's No. **1266**

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City	
d. FULL NAME OF HOSPITAL OR INSTITUTION St Lukes Hospital		d. STREET ADDRESS (If rural, give location) 3728 Baltimore	
3. NAME OF DECEASED a. (First) Maudie b. (Middle) (MAUDE) c. (Last) Bauer		4. DATE OF DEATH (Month) (Day) (Year) 3 17 1954	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH May 25, 1898
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Social Welfare Agency, KC, Mo.		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Stewartsville, Mo.
13a. FATHER'S NAME John Bauer		13b. MOTHER'S MAIDEN NAME Ella Roth KNORR	14. NAME OF HUSBAND OR WIFE *****
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. -	17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS Mrs. James Powell, Stewartsville, Mo.
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) Congestive Heart Failure ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Mitral Stenosis DUE TO (c) Rheumatic Fever II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
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)		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 3-8 , 19 54 , to 3-17 , 19 54 , that I last saw the deceased alive on 3-17 , 19 54 , and that death occurred at 9:50 p.m. , from the causes and on the date stated above.			
23a. SIGNATURE V. B. Ballard (Degree or title) MD		23b. ADDRESS 411 Nichols Rd. Kansas City Mo.	23c. DATE SIGNED 3-19-54
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 3/18/54	24c. NAME OF CEMETERY OR Ridgeville	24d. LOCATION (City, town, or county) (State) Stewartsville, Mo.
DATE REC'D BY LOCAL REG. 3-22-54	REGISTRAR'S SIGNATURE Heraldine Smith	25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS W.E. Humphreys Stewartsville, Mo.	

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

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 W. E. Summers

Licensed Embalmer No. 3007

P. O. Address Stewartsville, 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.