

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

43024

STATE FILE NUMBER 2934

FILED DEC 10 1957

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2934

|  |                                  |   |   |   |   |
|--|----------------------------------|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>St. Louis</b>  |                                  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis City</b> |   |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR<br>TOWN <b>Normandy</b>  |                                  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | c. CITY<br>OR<br>TOWN <b>St. Louis -</b>  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>              |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR<br>INSTITUTION <b>Penn Nursing Home</b>   |                                  | Length of stay in lb<br><b>20 mos.</b>  | d. STREET<br>ADDRESS <b>4067a DeTonty</b>   |   | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>             |
| 5. NAME OF DECEASED<br>(Type or print)<br>First <b>MARY</b> Middle <b>A.</b> Last <b>BAER</b>  |                                  |   | 4. DATE OF DEATH<br>Month <b>Nov.</b> Day <b>22</b> Year <b>1957</b>  |   |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Aug. 27, 1870</b>  | 9. AGE (In years last birthday)<br><b>87</b>              | IF UNDER 1 YEAR<br>Months Days Hours Min.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>None At home</b>  | 11. BIRTHPLACE (City and state or country)<br><b>St. Louis, Mo.</b>   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>             |   |
| 13a. FATHER'S NAME<br><b>Matthew Bradshaw</b>  |                                  | 13b. MOTHER'S MAIDEN NAME<br><b>Anastasia McGraw</b>  |   | 14. NAME OF HUSBAND OR WIFE<br><b>Alexander Baer</b>      |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No None</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>None</b>  | 17. INFORMANT<br>Address<br><b>John Baer 4067a DeTonty</b>  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral malacia</b>  |                                  |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>unknown</b>  |
| DUE TO (b) <b>Cerebral thromboses 4221</b>   |                                  |   |   |   | <b>unknown</b>  |
| Conditions, if any, which gave rise to above cause (a), starting the underlying cause last. DUE TO (c) <b>Arteriosclerotic Cardiovascular disease</b>  |                                  |   |   |   | <b>unknown</b>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>Cerebral arteriosclerotic dementia</b>   |                                  |   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>  |                                  |   | 20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in PART I or PART II of item 18.)  |   |   |
| 20c. TIME OF INJURY<br>Hour Month, Day, Year<br>a.m.<br>p.m.   |                                  |   |   |   |   |
| 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                                  | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |   | 20f. CITY, TOWN, OR LOCATION COUNTY STATE                 |   |
| 21. I attended the deceased from <b>March 16, 1956</b> , to <b>Nov 23, 1957</b> and last saw her alive on <b>11/19/57</b><br>Death occurred at <b>9:30 P.</b> m on the date stated above; and to the best of my knowledge, from the causes stated. |                                  |   |   |   |   |
| 22a. SIGNATURE <b>Lewis Littmann MD</b> (Degree or title)  |                                  |   | 22b. ADDRESS <b>8231 Clayton Rd (17)</b>  |   | 22c. DATE SIGNED <b>11/23/57</b>  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>  |                                  | 23b. DATE<br><b>Nov. 25, 1957</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Calvary Cemetery</b>   |   | 23d. LOCATION (City, town, or county) (State)<br><b>St. Louis, Mo.</b>                            |
| 24. FUNERAL DIRECTOR<br><b>Kriegshauser Mortuaries</b><br>ADDRESS<br><b>4228 So. Kingshighway Blvd</b>   |                                  |   | 25. DATE RECD. BY LOCAL REG.<br><b>11-23-57</b>   | 26. REGISTRAR'S SIGNATURE<br><b>Herbert B. Danaher MD</b> |   |

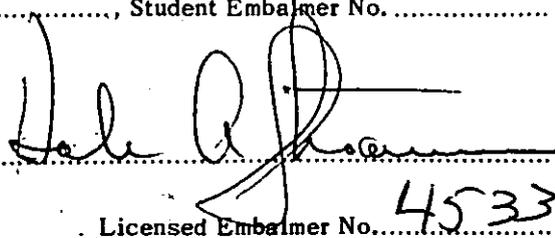
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 .....  
Signature of Student Embalmer

Signed  .....,  
Licensed Embalmer No. 4533

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.