

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-006984

STATE FILE NUMBER

FILED MAR 5 - 1958

Registration District No. 318 Primary Registration District No. 1003

Registrar's No. 2014

300
-57

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1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Deaconess Hospital		Length of stay in lb 40 yrs	d. STREET ADDRESS (If outside, give location) 21490 6212 Chippewa Street		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last CLARA A. BAESE			4. DATE OF DEATH Month Day Year Feb. 18, 1958		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 30, 1896	9. AGE (In years last birthday) 61	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY at home	11. BIRTHPLACE (City and state or country) Altenburg, Missouri	12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Jacob H. Grebing		13b. MOTHER'S MAIDEN NAME Louise K. J. Anderman		14. NAME OF HUSBAND OR WIFE Edward Herman Baese	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. --	17. INFORMANT Address Mrs. Elaine Shearman, 1408 Woodland Drive		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Toxemia - beta streptococcus infection</i> <i>left radical mastectomy for carcinoma of left breast</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>left radical mastectomy for</i> DUE TO (c) <i>carcinoma of left breast</i>					INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i> <i>1 mo.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.) <i>170 x</i>		
20c. TIME OF INJURY Hour Month, Day, Year a.m. 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 <i>2/11/58</i> to <i>2/17/58</i> and last saw her ^{her} alive on <i>2/19/58</i> Death occurred at <i>12:50 A</i> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>Robert M. Kurth</i> (Type or print) M.D.			22b. ADDRESS <i>Hampton Village Hampton Village, Ind. Bldg</i>		22c. DATE SIGNED <i>2/19/58</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>removal</i>	23b. DATE <i>Feb. 22, 1958</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Our Redeemer Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>St. Louis County, Missouri</i>	
24. FUNERAL DIRECTOR ADDRESS <i>BEIDERWIEDEN F.H. INC., 1936 St. Louis Av</i>			25. DATE RECD. BY LOCAL REG. <i>FEB 20 '58</i>	26. REGISTRAR'S SIGNATURE <i>Carl Smith M.D.</i>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

Dr. Robert Kurth
16 Hampton Medical Center
IPM on

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 Delia J. Krupar

Licensed Embalmer No. 3497
P. O. Address St. Louis

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.