

Health, Welfare  
Public Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-002689  
STATE FILE NUMBER  
2 862

Registration District No. Primary Registration District No. Registrar No.

FILED FEB 16 1959

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
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 Hillsdale 4/6/1 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis State H.		Length of stay in 1b	d. STREET ADDRESS 2139 68th St., St. L. Co (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last Ivah E. Bach			4. DATE OF DEATH Month Day Year Jan. 24, 1959		
--	--	--	---	--	--

5. SEX Female 1	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 11, 1886	9. AGE (In years last birthday) 72	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
--------------------	---------------------------	---	-----------------------------------	---------------------------------------	---	--------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Fulton, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
--	-----------------------------------	---	--

13a. FATHER'S NAME John L. Harris	13b. MOTHER'S MAIDEN NAME Ida Goodman	14. NAME OF HUSBAND OR WIFE Fred W. Bach
--------------------------------------	--	---

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. None	17. INFORMANT Fred W Bach 2139 68th St. Address
---	---------------------------------	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal obstruction Volvulus, multiple with gangrene Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) 570.3		INTERVAL BETWEEN ONSET AND DEATH
--	--	----------------------------------

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Aspiration bronchopneumonia, bilateral with abscesses		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.)
---	--

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 Death occurred at 8:45 November 16, 1955 to January 24, 1959 P m on the date stated above; and to the best of my knowledge, from the causes stated. and last saw her alive on Jan. 24, 1959
--

22a. SIGNATURE (Name or title) Joseph Joseph Gagliardo, M.D.	22b. ADDRESS 5400 Arsenal St.	22c. DATE SIGNED 1/25/59
---	----------------------------------	-----------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 1-27-59	23c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis Co, Missouri
--	----------------------	--	---

24. FUNERAL DIRECTOR J.W. Clark F.H. 1125 Hodiamont Ave.	25. DATE RECD. BY LOCAL REG. JAN 26 '59	26. REGISTRAR'S SIGNATURE J. Carl Smith M.D. S.P.
---	--	---

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

300  
-57  
31  
35  
2

FEB 28 1964

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 *Alfred J. Boedeker* .....

Licensed Embalmer No. *2663*

P. O. Address *11257 Hudson*

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.