

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED **6 AUG 26 1960**
 District No. **318**

Primary Registration District No. **1003**

Registrar's No.

8197-60-031829
 STATE FILE NUMBER

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, Missouri.		Length of stay in 1b 13 years		c. CITY OR TOWN St. Louis		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. Anthony's Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 2260 South Jefferson Ave.,		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) Rose Bader				4. DATE OF DEATH Month August Day 18 Year 1960											
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 10/26/1877		9. AGE (last birthday) 82		IF UNDER 1 YEAR Months Days		IF UNDER 24 HR 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 At Home				11. BIRTHPLACE (City and state or country) Ste. Genevieve, Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.					
13a. FATHER'S NAME William F. Klein				13b. MOTHER'S MAIDEN NAME Christine Roth				14. NAME OF HUSBAND OR WIFE William Bader, dec'd							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No Nil				16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Elizabeth Joyce, 1311 Pennsylvania.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Tuberculosis and pneumonia DUE TO (b) Empyema following Pneumonia 2 wks DUE TO (c) R Power 490+ <p>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)</p> <p>PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown</p>															
19. WAS AUTOPSY PERFORMED? 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 Hour a.m. p.m. Month, Day, Year				20d. INJURY OCCURRED WHILE AT WORK <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 Aug 8 - 1960 to Aug 18 - 1960 and last saw her/him alive on Aug 18 - 1960 Death occurred at 4:50 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.															
22a. SIGNATURE (Degree or title) Robert J. Glover						22b. ADDRESS N 00 Olive St			22c. DATE SIGNED 8-19-60						
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 8/22/60		23c. NAME OF CEMETERY OR CREMATORY Ste. Genevieve Cemetery				23d. LOCATION (City, town, or county) Ste. Genevieve, Missouri.		(State)					
24. FUNERAL DIRECTOR Albert H. Hoppe Inc., 4700 Washington Blvd.,				25. DATE RECD. BY LOCAL REG. AUG 19 1960		26. REGISTRAR'S SIGNATURE Carl Smith, M.D.									

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Harry E. Monroe

Licensed Embalmer No. 4495

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