

AMENDED Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8536 STATE FILE NUMBER

DATE AMENDED

INSTEAD OF DOCUMENT

ITEM NO. SHOULD READ BY AFFIDAVIT OF

FILED SEP 21 1961

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Jefferson		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b <u>20 Days</u>	c. CITY OR TOWN Festus		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. Johns Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 134 Grey St.,		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last DORA (VICTORIA) M. BAHR			4. DATE OF DEATH Month Day Year Sept. 10, 1961		
5. SEX Female	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 10-18-1890	9. AGE (last birthday) 70
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) Ste. Genevieve Co., Mo	12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Andrew Fischer		13b. MOTHER'S MAIDEN NAME Caroline Joggerst		14. NAME OF HUSBAND OR WIFE Frank X. Bahr	
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 Address Frank X. Bahr, 134 Grey St. Festus, Mo		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SARCOMA of MESENTERY</u> DUE TO (b) <u>ATALECTASIS of Lung</u> DUE TO (c) <u>158X</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>1 Mo.</u> <u>4 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)				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	
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 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 <u>8/30/61</u> to <u>9/10/61</u> and last saw her <del>him</del> live on <u>9/9/61</u> Death occurred at <u>9 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22. SIGNATURE (Degree or title) <u>Loane Sauer, M.D.</u>			22b. ADDRESS <u>7820 Carondelet Ave</u>		22c. DATE SIGNED <u>9/11/61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 9-13-61	23c. NAME OF CEMETERY OR CREMATORY Catholic	23d. LOCATION (City, town, or county) (State) Festus-Crystal City, Mo.		
24. FUNERAL DIRECTOR ADDRESS Vinyard Funeral Home, Inc. Festus, MO.		25. DATE RECD. BY LOCAL REG. SEP 13 1961	26. REGISTRAR'S SIGNATURE <u>Loane Smith, M.D.</u>		

**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. 3010

P. O. Address Foster

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.