

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH  
DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=63-017348

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **4759** STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED MAY 9 1963

VS 300  
Rev. 4/59  
1  
2 223  
3  
4 0  
5 1  
6  
7 1  
8 1  
9  
10  
11  
12 65-0  
13

DATE AMENDED  
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
INSTEAD OF  
SHOULD READ

DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		b. COUNTY		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
		St. Louis		4 Mons		Missouri		St. Louis				
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)						
Lutheran Hospital						1909 Lynch St						
3. NAME OF DECEASED (Type or print)			First		Middle		Last		4. DATE OF DEATH Month Day Year			
Oscar Albert Baum									4-29-1963			
5. SEX		6. COLOR OR RACE		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (last birthday)		IF UNDER 1 YEAR Months Days Hours Min.		
Male		White				6-6-1908		54 Yrs				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (City and state or country)		12. CITIZEN OF WHAT COUNTRY		
Freight Handler				Anheuser-Busch				Ruma Illinois		U.S.A.		
13a. FATHER'S NAME				13b. MOTHER'S MAIDEN NAME				14. NAME OF HUSBAND OR WIFE				
Edward Baum				Jessie Walsh				Catherine Baum				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of)				16. SOCIAL SECURITY NO.		17. INFORMANT Address						
W.W.#2				2		Catherine Baum 1909 Lynch St						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:											INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a)											1 yr	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.											1 yr	
DUE TO (b)											153.8	
DUE TO (c)												
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 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>9/1/62</u> to <u>4/29/63</u> and last saw her/him alive on <u>4/29/63</u> Death occurred at: <u>11:30 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.												
22a. SIGNATURE (Degree or title)						22b. ADDRESS			22c. DATE SIGNED			
Friede Mortensen M.D.						3701 Brandel Sq			5/1/63			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town, or county) (State)				
Removal		5-2-1963		National Cemetery				Jefferson Barracks Mo Mo				
24. FUNERAL DIRECTOR ADDRESS						25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE				
Fendler Und. Co. 7420 Michigan Ave (11)						MAY 1 1963		Loan Smith, M.D.				

USE BLACK INK OR TYPEWRITER RIBBON

**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 W. G. Peterson

Licensed Embalmer No. 3767

P. O. Address 7420 Michigan

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.

Dr. Morgenson 3701 Grand  
Je 3-4430  
12:30 till 4:00 Wed