

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Alexian Brothers Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

8. (a) PRINT FULL NAME Joseph Bader

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Delma 6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased March 22 - 1860
(Month) (Day) (Year)

8. AGE: Years 70 Months 9 Days 29 If less than one day _____ hr. _____ min.

9. Birthplace Ste Genevieve Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Retired merchant

MOTHER FATHER
11. Industry or business _____
12. Name Louis Bader
13. Birthplace Germany
(City, town, or county) (State or foreign country)
14. Maiden name Mary Oberle
15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Joseph Bader

(b) Address Ste Genevieve, Mo

17. (a) Burial (b) Date thereof 1-23-1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ste Genevieve, Mo

18. (a) Signature of funeral director Louis H Bopp Inc

(b) Address Hertwood, Mo

19. (a) JAN 21 1941 (b) J T Bredeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Ste Genevieve
(c) City or town Bloomsdale
(If outside city or town limits, write "RURAL")
(d) Street No. None
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 1 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan 20th 1941
year _____ hour 1:45 AM minute _____ M.

21. I hereby certify that I attended the deceased from Jan 15 - 1941
to Jan 20 - 1941
that I last saw him alive on Jan 20
and that death occurred on the date and hour stated above.

Immediate cause of death Auricular fibrillation
Myocardial degeneration
Arteriosclerosis
Hypertrophied prostate with
complete urinary retention
Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: marked hypertrophied prostate
Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Stephen M. Gupper MD (M. D. or other)
Address 229 F. road Bldg Date signed 11/21/41

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 _____
_____, Registered Apprentice No. _____
working under my personal supervision.

Signed John M Meyer
Licensed Embalmer No. 3288
P. O. Address Urbanwood, 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 this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 6517

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 651

1. PLACE OF DEATH:

(a) County St Louis
(b) City or town.....
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
(Specify whether
In this community.....
years, months or days)

3. (a) PRINT FULL NAME Joseph Bader
3. (b) If veteran..... name war.....
3. (c) Social Security No.....

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... year.....

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
70 9 29 hr. min.

9. Birthplace..... (City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace..... (City, town, or county) (State or foreign country)

14. Maiden name..... (State or foreign country)

15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant.....

(b) Address.....

17. (a)..... (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) 7-15-41 (b) J.F. Bredeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....
(c) City or town..... (If outside city or town limits, write "RURAL")
(d) Street No..... (If rural, give location)
(e) Citizen of foreign country..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 20
year 1941 hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....; that last saw h..... alive on....., 19....., and that death occurred on the date and hour stated above.

Immediate cause of death Auricular Fibroid

myocardial degeneration

Due to arteriosclerosis

hypertrophied prostate

Due to with complete urinary retention

Other conditions..... (Include pregnancy within 3 months of death) 1370

Major findings: Masked Hypertrophied prostate 1-19-41

Of autopsy.....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....

(b) Date of occurrence.....

(c) Where did injury occur?..... (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?.....

While at work?..... (Specify type of place) (e) Means of injury.....

23. Signature Stephen M. Tappin (M. D. or other)

Address 729 Pine Bluff Date signed.....

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTAL

