

Registration District No. **782 15 18**

Primary Registration District No. **6028**

Registrar's No. **28**

1. PLACE OF DEATH

(a) County **St. Genevieve Arkansas**
(b) City or town **Bloomsville Mo.**
(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

8. (a) PRINT FULL NAME **Caroline Bayer Lass**

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

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife **(late) Charles Bayer** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **Nov. 11, 1867**
(Month) (Day) (Year)

8. AGE: Years **72** Months **6** Days **30** If less than one day hr. _____ min. _____

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

10. Usual occupation **housework** **6**

11. Industry or business **at home** **6**

12. Name **Andrew Sewald**

13. Birthplace **Germany** (State or foreign country)

14. Maiden name **Mary Oberle**

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

16. (a) Informant **U. A. Bayer**

(b) Address **St. Louis, Mo.**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof: **6-13-40**
(Month) (Day) (Year)

(c) Place: burial or cremation **ST. Philomnie Cem.**

18. (a) Signature of funeral director **Southern Med. Co. Bloomsville**

(b) Address **612 S Grand - St. Louis Mo**

19. (a) **June 12/40** (b) **T. W. Douglas**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **St. Gen**

(c) City or town **Bloomsville**
(If outside city or town limit write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **10**
year **1940** hour _____ minute **3:30** P. M.

21. I hereby certify that I attended the deceased from **Feb 2 1938**
_____ 19____ to **June 10** 19____
that I last saw her alive on **June 10** 19____
and that death occurred on the date and hour stated above.

Immediate cause of death **Pericarditis Myemia** **12 yrs**

Due to **92 C**

Due to _____

Other conditions **Chronic Myocarditis** **1928**
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: Of operations _____

Of autopsy _____

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? **700**

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

23. Signature **Arthur E. Sawyer** (M. D. or other) **M.D.**

Address **St. Genevieve Mo** Date signed **6-12-40**

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

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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.....

Frank Ludwig

Licensed Embalmer No. *2504*

P. O. Address

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.