

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

15179

1. PLACE OF DEATH  
 County Terry Registration District No. 1659  
 Township Lincoln Home Primary Registration District No. 5876  
 City (No. City No. Ward)  
 2. FULL NAME Maurus Henry Biehle  
 (a) Residence No. St. Ward. (If nonresident, give city or town and State)  
 (Usual place of abode)  
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. APR 25 1931

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Rosa Biehle  
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 17 1885  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
45 8 14  
 8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work Farmer  
 (b) General nature of industry, business, or establishment in which employed (or employer)  
 (c) Name of employer  
 9. BIRTHPLACE (CITY OR TOWN) Biehle Mo (STATE OR COUNTRY)  
 10. NAME OF FATHER Joseph Biehle  
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Terry Co Mo (STATE OR COUNTRY)  
 12. MAIDEN NAME OF MOTHER Wilhelmina Baer  
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Biehle Mo (STATE OR COUNTRY)  
 14. INFORMANT Rosa Biehle (Address) Biehle Mo  
 15. FILED 4:6 1931 Martin Moeckel REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 5 1931  
 17. I HEREBY CERTIFY, That I attended deceased from Jan 17th 1931, to April 5th 1931, that I last saw him alive on April 4th 1931, and that death occurred, on the date stated above, at 10:20 a.m.  
 THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Pulmonary Tuberculosis  
23F (duration) 1 yrs. 0 mos. 0 ds.  
 CONTRIBUTORY (SECONDARY) 23 (duration) 0 yrs. 0 mos. 0 ds.  
 18. WHERE WAS DISEASE CONTRACTED 0  
 IF NOT AT PLACE OF DEATH.....  
 DID AN OPERATION PRECEDE DEATH? No DATE OF.....  
 WAS THERE AN AUTOPSY? No  
 WHAT TEST CONFIRMED DIAGNOSIS? Clinical  
 (Signed) Wm. H. Bailey, M. D.  
 , 19 (Address) Terryville Mo  
 \*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.  
 19. PLACE OF BURIAL, CREMATION, OR REMOVAL Biehle Cemetery DATE OF BURIAL April 7 1931  
 20. UNDERTAKER Zoellner & Young ADDRESS Terryville Mo

state  
ent.

state  
of exact

Page 11  
ADDS D

2

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Perry Registration District No. 659 File No. \_\_\_\_\_  
 Township Circuit Home Primary Registration District No. 3876 Registered No. 65-  
 City \_\_\_\_\_ (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME Manus Henry Diehle

(a) Residence No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of abode) (If nonresident give city or town and State)  
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 21 1858

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
45 8 14

8. OCCUPATION OF DECEASED

- (a) Trade, profession, or particular kind of work \_\_\_\_\_  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
 (c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY) \_\_\_\_\_

10. NAME OF FATHER \_\_\_\_\_

11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY) \_\_\_\_\_

12. MAIDEN NAME OF MOTHER \_\_\_\_\_

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY) \_\_\_\_\_

14.

INFORMANT \_\_\_\_\_  
 (Address) \_\_\_\_\_

FILED April 6, 19 Martin W. Mochel REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 5 1931

17. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw him \_\_\_\_\_, also on \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

\_\_\_\_\_ (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) \_\_\_\_\_ (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_

(Signed) \_\_\_\_\_, M. D.  
 \_\_\_\_\_, 19\_\_\_\_ (Address)

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_

20. UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state USE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-15779