

FILED MAR 10 1943
Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **1937**

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

1. PLACE OF DEATH:

(a) County _____

(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
3611 Osceola St.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days)

3. (a) PRINT FULL NAME **August A. Bieker**

3. (b) If veteran, name war **World #1** 3. (c) Social Security No. **No.**

4. Sex **Male 0** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Mary Bieker** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **February 4, 1889**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
54 0 21 hr. min.

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

10. Usual occupation **Executive**

11. Industry or business **Dental Labratory**

12. Name **Anton Bieker**

13. Birthplace **Germany 4**
(City, town, or county) (State or foreign country)

14. Maiden name **Anna Leibfried**

15. Birthplace **Germany 4**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Mary Bieker**

(b) Address **3611 Osceola St.**

17. (a) **Burial** (b) Date thereof **3/1/43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cemetery**

18. (a) Signature of funeral director **Weick Bros.**

(b) Address **2201 S. Grand Bl.**

19. (a) **FEB 27 1943** (b) **J. F. Bredesch**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County _____

(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")

(d) Street No. **3611 Osceola St.**
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb.** day **25**
year **1943** hour **7** minute **0** P. M.

21. I hereby certify that I attended the deceased from **April 27**, 19**42**, to **Feb. 25**, 19**43**;
that I last saw him alive on **February 24**, 19**43**;
and that death occurred on the date and hour stated above.

Immediate cause of death: **Coronary thrombosis 1 day**

Due to: **Chronic Hypertension 1 yr.**

Due to: _____

Other conditions: **A 2**
(Include pregnancy, within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

Duration
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 **Anton Bredesch** (M. D. or other) **MD.**
Address **2202 St. Vincent St.** Date signed **2/26/43**

Dr. Sundlach
2202 University St.

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 *Mary A. Stewart*

Licensed Embalmer No. 3722

P. O. Address. 412 Duchouquette St.

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, fact should be so stated above.