

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
THE STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. ....

**FILED** JUN 26 1946  
318

Registration District No. .... Primary Registration District No. **1002** Registrar's No. **5418**

1. PLACE OF DEATH:  
(a) County **St. Louis Mo.**  
(b) City or town **St. Louis Mo.**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**Barnes Hospital**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution.....  
In this community.....  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Missouri** (b) County **Gasconade 37**  
(c) City or town **Bland**  
(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.....

3. (a) PRINT FULL NAME **Betty Jean Biehl**  
3. (b) If veteran, name war **No** 3. (c) Social Security No. **None**  
4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Single**  
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years  
7. Birth date of deceased **Feb. 14 1931**  
(Month) (Day) (Year)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **June** day **18**  
year **1946** hour **12** minute **55** P.M.  
21. I hereby certify that I attended the deceased from **May 14**, 1946, to **June 18**, 1946  
that I last saw her alive on **June 18**, 1946  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
**15 4 4** hr. min.

Immediate cause of death **Subacute bacterial endocarditis**  
Due to **Patent ductus arteriosus**  
Due to.....  
Other conditions (Include pregnancy within 3 months of death) **157**

9. Birthplace **Bland Missouri**  
(City, town, or county) (State or foreign country)  
10. Usual occupation **Child**

Major findings:  
Of operations **patent ductus arteriosus**  
Of autopsy **Same**

11. Industry or business.....  
12. Name **Benjamin Biehl**  
13. Birthplace **Bland Missouri**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Albia Schockley**  
15. Birthplace **Gasconade Missouri**  
(City, town, or county) (State or foreign country)

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.....

16. (a) Informant **Benjamin Biehl**  
(b) Address **Bland, Mo.**  
17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **6-20-46**  
(Month) (Day) (Year)  
(c) Place: burial or cremation **Bland, Mo.**

23. Signature **Gordon F. Moore** (M. D.)  
Address **Barnes Hospital** Date signed **6/18/46**

18. (a) Signature of funeral director **Albert H. Hoppe**  
(b) Address **4700 Washington Blvd.**  
19. (a) **JUN 19 1946** (Date received local registrar) **J. F. Brudeck** (Registrar's signature)

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

MOTHER FATHER

Duration **1 1/2 yrs**  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

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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.....

*Albert G. Hopper*

Licensed Embalmer No.....

*2971*

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, fact should be so stated above.**