

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **6245**
Registrar's No. **1689**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Jewish Hospital | | d. STREET ADDRESS (If rural, give location) 5954 North Point | |

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|--|------------|------------------------|------------------------|---|
| 3. NAME OF DECEASED (Type or Print) Josephine | a. (First) | b. (Middle) --- | c. (Last) Biest | 4. DATE OF DEATH (Month) (Day) (Year) Feb. 21 1952 |
|--|------------|------------------------|------------------------|---|

| | | | | | | | | |
|----------------------|-------------------------------|---|-------------------------------------|---|------------------------|----------------------|-----------------------|----------------------|
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed | 8. DATE OF BIRTH Jan 25 1877 | 9. AGE (In years last birthday) 75 | IF UNDER 1 YEAR Months | IF UNDER 1 YEAR Days | IF UNDER 1 YEAR Hours | IF UNDER 1 YEAR Min. |
|----------------------|-------------------------------|---|-------------------------------------|---|------------------------|----------------------|-----------------------|----------------------|

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|--|-----------------------------------|--|---------------------------------------|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) England | 12. CITIZEN OF WHAT COUNTRY? 4 |
|--|-----------------------------------|--|---------------------------------------|

| | | |
|---|---|---|
| 13a. FATHER'S NAME Michael Collins | 13b. MOTHER'S MAIDEN NAME Katherine Conghlin | 14. NAME OF HUSBAND OR WIFE William J. Biest |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT'S SIGNATURE OR NAME Nellie Collins | ADDRESS 5954 North Point |
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| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i> | MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hemiplegia (right) | | 5 days |
| | ANTECEDENT CAUSES DUE TO (b) Arteriosclerosis Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis | | | 5 yrs |

| | | |
|------------------------|----------------------------------|--|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
|------------------------|----------------------------------|--|

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|--|--|---|
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) |
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| | | |
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| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR 334X |
|--|--|---------------------------------------|

22. I hereby certify that I attended the deceased from **Dec. 19 47**, to **Feb. 21, 1952**, that I last saw the deceased alive on **2/21**, 1952, and that death occurred at **11:45p.m.**, from the causes and on the date stated above.

| | | | |
|---|-------------------|--|---------------------------------|
| 23a. SIGNATURE P. D. Stahl m. D. | (Degree or title) | 23b. ADDRESS 462 N. Taylor Ave. | 23c. DATE SIGNED 2/22/52 |
|---|-------------------|--|---------------------------------|

| | | | |
|---|--------------------------|---|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) burial | 24b. DATE 2/25/52 | 24c. NAME OF CEMETERY OR CREMATORY Bellefontaine | 24d. LOCATION (City, town, or county) (State) St. Louis Mo. |
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|---|--|---|---------------------------------|
| DATE REC'D BY LOCAL REG. FEB 23 1952 | REGISTRAR'S SIGNATURE J. Earl Smith, MD | 25. FUNERAL DIRECTOR'S SIGNATURE Drehmann-Harral | ADDRESS 1905 Union Blvd. |
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(Licensed Embalmer's Statement on Reverse Side)

WRITES PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Dr. D. Stahl,
462 N. Taylor Ave.,

(10 to 11)

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Albert R. Thompson

Licensed Embalmer No. 4237

P. O. Address St. Louis

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.