

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

44008

State File No.

No. 300
10. 48

JAN 8 - 1953

BIRTH NO. REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 542 Registrar's No. 3316

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Ferguson		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Ferguson	
d. FULL NAME OF HOSPITAL OR INSTITUTION 124 N. Marguerite Ave.		d. STREET ADDRESS (If rural, give location) 124 Marguerite	

3. NAME OF DECEASED (Type or Print) a. (First) Edwin	b. (Middle)	c. (Last) Bierman	4. DATE OF DEATH (Month) (Day) (Year) 12/27/52.
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH May 26, 1892	9. AGE (In years last birthday) 60	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours	IF UNDER 24 HRS. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tool & Die Maker	10b. KIND OF BUSINESS OR INDUSTRY Aircraft	11. BIRTHPLACE (State or foreign country) Keokuk, Iowa	12. CITIZEN OF WHAT COUNTRY? U. S.
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13a. FATHER'S NAME William Bierman	13b. MOTHER'S MAIDEN NAME Minnie Kammerer	14. NAME OF HUSBAND OR WIFE Rosita, Bierman
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or now) No	16. SOCIAL SECURITY NO. 481-03-3129	17. INFORMANT'S SIGNATURE OR NAME Rosita Bierman	ADDRESS Ferguson, Mo.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 2 hrs
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinomatosis		4 hrs
	ANTECEDENT CAUSES DUE TO (b) Adenocarcinoma, gastric 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. 15 IX			

19a. DATE OF OPERATION June 52	19b. MAJOR FINDINGS OF OPERATION Metastatic adeno carcinoma	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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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from June 1952 to Dec 1952, that I last saw the deceased alive on 21 Dec 1952 and that death occurred at 3:00 P.M., from the causes and on the date stated above.

23a. SIGNATURE D. H. Weaver (Degree or title) M.D.	23b. ADDRESS 40 N. Flouissant	23c. DATE SIGNED 12-27/52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 12/29/52	24c. NAME OF CEMETERY OR CREMATORY Oakwood Park Cemetery	24d. LOCATION (City, town, or county) (State) Hamilton, Illinois
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DATE REC'D BY LOCAL REG. 12-28-52	REGISTRAR'S SIGNATURE Hubert R. Donohue - M.D.	25. FUNERAL DIRECTOR'S SIGNATURE White Chapel, Ferguson, Mo.	ADDRESS
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(Licensed Embalmer's Statement on Reverse Side)

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

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 *L. M. White*

Licensed Embalmer No. *3973*

P. O. Address *Perguson, Mo*

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.