

STANDARD CERTIFICATE OF DEATH

State File No. **30593**

Registrar's No. **7850**

FILED SEP 29 1955

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 OR TOWN St Louis	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSPITAL		e. STREET ADDRESS (If rural, give location) 3011 Magnolia Av	
3. NAME OF DECEASED (Type or Print) WILLIAM		a. (First) BIECHER	c. (Last)
5. SEX Male		6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single
8. DATE OF BIRTH Abt 1873		9. AGE (In years last birthday) Abt 82	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Labor	11. BIRTHPLACE (City and State or Foreign Country) St Louis Missouri
12. CITIZEN OF WHAT COUNTRY? U S A		13a. FATHER'S NAME William Biecher	
13b. MOTHER'S MAIDEN NAME Katherine Klenkil		14. NAME OF HUSBAND OR WIFE None	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME Edna Yahraus		ADDRESS 4116a Virginia Av	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CEREBRAL HEMORRHAGE		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
* This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO (c) ↓ ARTERIOSCLEROSIS		

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

22. I hereby certify that I attended the deceased from **9-2**, **1955**, to **9-5**, **1955**, that I last saw the deceased alive on **9-5-55**, 19____, and that death occurred at **12:30 AM.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) William N. Blalock, M.D.	23b. ADDRESS 1515 LAFAYETTE AVE.	23c. DATE SIGNED 9-5-55
24a. BURIAL, CREMATION, REMOVAL Removal	24b. DATE 9/7/55	24c. NAME OF CEMETERY OR CREMATORY Oak Grove Mausoleum
24d. LOCATION (City, town, or county) (State) St Louis County Mo.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Moydell Funeral Home 1926 Allen Av	
DATE REC'D BY LOCAL REG. SEP 7 1955	REGISTRAR'S SIGNATURE Carl Smith M.D.	

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

No. 300
10.48

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.....
Signature of Student Embalmer

Signed *Reinhold K. Lohmann*.....

Licensed Embalmer No. *3395*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.