

FILED FEB 17 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. \_\_\_\_\_  
911  
Registrar's No. \_\_\_\_\_

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis</b>		c. LENGTH OF STAY (In this place) <b>25 days</b>		c. CITY OR TOWN <b>St. Louis</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>De Paul Hospital</b>				e. STREET ADDRESS (If rural, give location) <b>4893 Farlin Avenue</b>			
3. NAME OF DECEASED (Type or Print)		a. (First) <b>William</b>		b. (Middle) <b>Bietsch</b>		c. (Last) <b>Bietsch</b>	
4. DATE OF DEATH		(Month) <b>Jan</b>		(Day) <b>24</b>		(Year) <b>1956</b>	
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>		8. DATE OF BIRTH <b>July 11 1879</b>	
9. AGE (In years last birthday) <b>76</b>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 1 WEEK Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <b>Steam Fitter</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>unknown</b>			11. BIRTHPLACE (City and State or Foreign Country) <b>Okawville Illinois</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13a. FATHER'S NAME <b>George Bietsch</b>		13b. MOTHER'S MAIDEN NAME <b>Elizabeth Meier</b>		14. NAME OF HUSBAND OR WIFE <b>Florence Bietsch</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>492-03-9172</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs. Florence Bietsch, 4893 Farlin Avenue</b>			
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Pancreatitis, Cardiac Insufficiency</b> <i>Renovatoris, Cardiac Insufficiency</i> ANTECEDENT CAUSES <b>Toxemia - Toxemia - Renal Insufficiency</b> <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i> DUE TO (b) <b>Acute Rheumatoid arthritis</b> <i>Renal Insufficiency</i> DUE TO (c) <b>Acute Rheumatoid Arthritis</b> II. OTHER SIGNIFICANT CONDITIONS <b>Diabetic -</b> <i>Conditions contributing to the death but not related to the disease or condition causing death. Nephrotic acc. Diabetic DD.</i>				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <b>587.0</b>				20. AUTOPSY? YES <input checked="" 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 <b>12/23</b> , 19 <b>55</b> , to <b>1/24</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>1/24</b> , 19 <b>56</b> , and that death occurred at <b>6:30 pm.</b> , from the causes and on the date stated above.							
23a. SIGNATURE <b>Franklin P. Knight, M.D.</b> <i>Franklin P. Knight</i>				23b. ADDRESS <b>10011 Bellefontaine Rd.</b> <i>10011 Bellefontaine Rd.</i>		23c. DATE SIGNED <b>1/26/56</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>Jan 27 1956</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Friedens Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis Missouri</b>	
DATE REC'D BY LOCAL REG. <b>JAN 26 1956</b>		REGISTRAR'S SIGNATURE <b>J. Paul Smith M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Math Hermann &amp; Son, Inc., 2161 E. Fair Ave</b>			

J.P. (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.....  
Signature of Student Embalmer

Signed.....  
Licensed Embalmer No. 490

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.