

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-036961

FILED VS SEP 1 9 1960

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2562 STATE FILE NUMBER

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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, give TOWNSHIP only) OR TOWN Normandy, Mo.		Length of stay in 1b 18 Hrs.	c. CITY OR TOWN Berkeley Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION O'Sullivan Nursing Home		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 6309 Jackson Ave. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Albert Middle Biermann Last Biermann			4. DATE OF DEATH Month Aug. Day 28 Year 1960				
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11-15-85	9. AGE (last birthday) 74	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Time keeper		11. BIRTHPLACE (City and state or country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY U. S.	
13a. FATHER'S NAME Albert H. Biermann			13b. MOTHER'S MAIDEN NAME Agusta Loesing		14. NAME OF HUSBAND OR WIFE -----		

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 489-03-2627	17. INFORMANT Mrs. Julia Lewis, St. Louis, Mo.	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Unknown Natural Causes		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____	Month, Day, Year	

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION St. Louis, Mo.	COUNTY St. Louis	STATE Mo.
21. I attended the deceased from _____, to _____ and last saw her/him alive on _____ Death occurred at 11:20 A. m on the date stated above, and to the best of my knowledge, from the causes stated.				

21a. SIGNATURE (Degree or title) John C. Murphy M.D. Assy. Health Commissioner		22b. ADDRESS 801 S. Brentwood Clayton, Mo.	22c. DATE SIGNED 9/7/60
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 8-31-60	23c. NAME OF CEMETERY OR CREMATORY St. Peters Cemetery	23d. LOCATION (City, town, or county) St. Louis County, Mo.
24. FUNERAL DIRECTOR White-Mullen Mortuary, Ferguson, Mo.	ADDRESS	25. DATE RECD. BY LOCAL REG. 8-30-60	26. REGISTRAR'S SIGNATURE John C. Murphy M.D.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Reinhold K Lohman

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
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.