

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

18927

1. PLACE OF DEATH
 County Greene Registration District No. 318
 Township _____ Primary Registration District No. 2991 File No. _____
 City Springfield (No. 1162 W. Mt. Vernon) St. _____ Registered No. 312 Ward _____

2. FULL NAME William Otto Biederlinden Biederlinden
 (a) Residence No. 1162 W. Mt. Vernon Ward _____ 5-26-21
 (Usual place of abode) (If nonresident give city or town and State) CA
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE of Ella May

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 18-1864

7. AGE Years 62 Months 10 Days 5 If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Rtd
 (b) General nature of industry, business, or establishment in which employed (or employer) Mail Carrier
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Springfield (STATE OR COUNTRY) Mo

PARENTS
 10. NAME OF FATHER John Biederlinden
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Germany (STATE OR COUNTRY) _____
 12. MAIDEN NAME OF MOTHER Jenny Buckley
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ky (STATE OR COUNTRY) _____

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4/23 1928

17. I HEREBY CERTIFY, That I attended deceased from Apr. 22 1928, to Apr. 23 1928, that I last saw him alive on Apr. 22 1928, and that death occurred, on the date stated above, at 10:2 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Heart disease, hypertensive type
75 B
75 D (duration) 3 yrs. _____ mos. _____ da.

CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH: _____
 DID AN OPERATION PRECEDE DEATH? No DATE OF _____
 WAS THERE AN AUTOPSY? No
 WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) S. Hemmon, M. D.
4/23, 1928 (Address) SPRINGFIELD, MO.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Hazelwood Cem DATE OF BURIAL 4/24 1928

20. UNDERTAKER Alma Schmeyer ADDRESS 534 Stouis

14. INFORMANT Ella May Biederlinden
 (Address) Springfield Mo

15. 4/23 28 O. Horath
 FILED REGISTRAR

PHYSICAL

NOT SUPPLIED FOR

STATE OF

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Green Registration District No. 318 File No. _____
 Township _____ Primary Registration District No. 2001 Registered No. 312
 City Springfield (No. _____) St. _____ Ward _____

2. FULL NAME

William O. Bederlinden
 (a) Residence No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

M W M

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____
 (STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
 (STATE OR COUNTRY)

14.

INFORMANT (Address)

15.

4-23-08 Oct 1st 1908
 REGISTER

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4/23 1908

17. I HEREBY CERTIFY That I attended deceased from _____, 19____ that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Heart Disease
Hypertensive type
Nonvalvular, myocarditis
 (duration) _____ yrs. _____ mos. _____ ds.

State exact form of the heart disease, as mitral regurgitation, aortic stenosis; or valvular heart disease. Please sign and return. Hypertensive type heart disease in coron.

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) _____, M. D.

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS

Every information should be carefully checked. Exact statement of OCCUPATION is very important. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

