

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

Do not use this space.

20578
~~20076~~

1. PLACE OF DEATH

County St. Louis Co
Township Carrollton
City Carrollton

Registration District No. 1123

Primary Registration District No. B248 C

File No. _____
Registered No. 208
St. _____ Ward) _____

2. FULL NAME

Dora - Bella - Biekert

(a) Residence. No. 8023 - Dwarshoe Ave 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

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Married

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

Harry J. Biekert

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

April 13 - 1887

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>43</u>	<u>2</u>	<u>16</u>	

8. OCCUPATION OF DECEASED

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

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

Ill

10. NAME OF FATHER

James Blackford

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

Ill

12. MAIDEN NAME OF MOTHER

Bella Frost

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

St. Louis

14. INFORMANT (Address)

Harry J. Biekert
Vaffton Mo P. O

15. FILED

June 30, 1930
L. C. Obrock
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 29th 1930.

17. I HEREBY CERTIFY, That I attended deceased from 6-22-30, 1930, to 6-29-30, 1930, that I last saw her alive on 6-29-30, 1930, and that death occurred, on the date stated above, at 11:30 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Labor Pneumonia

1930 (duration) 8 yrs. 8 mos. 8 ds.
CONTRIBUTORY (SECONDARY) Cardiac Asthena
(duration) ? yrs. ? mos. ? ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

NO DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) A. G. Hallenried M. D.

, 19 (Address) 8200th Gravois

*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

San Set. Park Cemetery July 2 1930

20. UNDERTAKER

ADDRESS

Edw. J. Howard
4212
St. Louis Ave

N. B.—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 very important.

