

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

Do not use this space.

1. PLACE OF DEATH

County _____ Registration District No. _____
Township _____ Primary Registration District No. _____
City St. Louis Mo. (No. 2917 Cherokee St.) St. _____ Ward _____

File No. 28250
Registered No. 8096
St. _____ Ward _____

2. FULL NAME Charles Bieger

(a) Residence, No. 2917 Cherokee St. St. 24 Ward _____
(Usual place of abode)

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Widowed</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>March 25 1844</u>		
7. AGE YEARS <u>86</u>	MONTHS <u>4</u>	DAYS <u>15</u>
If LESS than 1 day, _____ hrs. or _____ min.		
8. OCCUPATION OF DECEASED: (a) Trade, profession, or particular kind of work. <u>Trunk Mfg.</u> (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) Germany

PARENTS

10. NAME OF FATHER Wm Bieger

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____

(STATE OR COUNTRY) Germany

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____

(STATE OR COUNTRY) Germany

14. INFORMANT Henny W. Bieger

(Address) 2917 Cherokee St.

15. FILED AUG 13 1930 Wm C. Stork REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 10 - 1930

17. I HEREBY CERTIFY, That I attended deceased from January 4, 1930 to August 10, 1930 that I last saw him alive on August 9, 1930 and that death occurred, on the date stated above, at 11:55 A.M.

18. THE CAUSE OF DEATH* WAS AS FOLLOWS:

131
17219
Myocardial Stenosis (duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY Chronic Interstitial (SECONDARY)
Nephritis (duration) 1+ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? visual

(Signed) William Brazon, M. D.

8/11, 1930, (Address) 212 Sidney

*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

Mount Hope Cem. 8-13-1930

20. UNDERTAKER

Ziegenhain Bros. 2623 Cherokee St.

DATE OF BURIAL

ADDRESS

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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 is very important.

