

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **18070**
Registrar's No. **194**

Registration District No. **125** Primary Registration District No. **3009**

1. PLACE OF DEATH:

(a) County **Cape Girardeau**
(b) City or town **Cape Girardeau**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Francis Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **3 days** (Specify whether
In this community years, months or days)

8. (a) PRINT FULL NAME **John Biler 460**
3. (b) If veteran name war **none** 3. (c) Social Security No. **none**

4. Sex **male** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **married**
6. (b) Name of husband or wife **Anna Biler** 6. (c) Age of husband or wife if alive years
7. Birth date of deceased **Month 16 1867** (Month) (Day) (Year)

8. AGE: Years **73** Months **2** Days **19** If less than one day hr. min.

9. Birthplace **Nalgate Ohio** (City, town, or county) (State or foreign country)
10. Usual occupation **Fisher Mills**

11. Industry or business
12. Name **William Biler**
13. Birthplace **Germany** (City, town, or county) (State or foreign country)
14. Maiden name **Catherine Redner**
15. Birthplace **Ohio** (City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Calvin Crozens**
(b) Address **new modied mo**
17. (a) **Burial** (b) Date thereof **6 8 1940** (Month) (Day) (Year)
(c) Place: burial or cremation **Caryman new modied mo**

18. (a) Signature of funeral director **J. A. Richards**
(b) Address **new modied mo**
19. (a) **6-7-40** (b) **J. M. Thompson** (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **mo** (b) County **new modied**
(c) City or town **Lieberman mo** (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **5**
year **1940** hour **11** minute **15 P. M.**
21. I hereby certify that I attended the deceased from **6/3** 1940, to **6/5** 1940;
that I last saw him alive on **6/5** 1940,
and that death occurred on the date and hour stated above.

Immediate cause of death
Hyp. Prostate
Due to **UREMIA**
Due to **Oper - Cystotomy**
Other conditions (include pregnancy within 3 months of death)

PHYSICIAN
Major findings:
Of operations **121**
Of autopsy
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
121 (Specify type of place) (e) Means of injury _____
While at work? _____
23. Signature **A. D. Smith** (M. D. or other) Date signed **6/7/40**
Address _____

WRITE PLAINLY—USE 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.....
..... Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

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 this body is not embalmed, above space should be left blank.