

NOV 20 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **35984**

Registration District No. **660**

Primary Registration District No. **4396**

Registrar's No. _____

1. PLACE OF DEATH: **Perry**
 (a) County **Perryville Mo.**
 (b) City or town **Perryville Mo.**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **77-11-8** (Specify whether **2**)
 In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Perry**
 (c) City or town **Perryville Mo.**
(If outside city or town limits, write "RURAL")
 (d) Street No. **0**
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME **August Bierk**
 3. (b) If veteran, name war _____
 3. (c) Social Security No. **None**

4. Sex **Male** 5. Color or race **White**
 6. (a) Single, widowed, married, divorced **Widowed**
 6. (b) Name of husband or wife **Lena M. Bierk**
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased **Oct. 6 1862**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	77	11	8	hr. _____ min.

9. Birthplace **Perry Co. Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Carpenter**

11. Industry or business _____

12. Name **John Bierk**

13. Birthplace **Germany**
(City, town, or county) (State or foreign country)

14. Maiden name **Catherine Wilhelm**

15. Birthplace **Germany**
(City, town, or county) (State or foreign country)

16. (a) Informant **Dr. J. J. ...**

(b) Address **...**

17. (a) **Burial** (b) Date thereof **Sept. 17 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Perryville Mo.**

18. (a) Signature of funeral director **Young & Sons**

(b) Address **Perryville Mo.**

19. (a) **9-17-40** (b) **Jos. J. ...**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept.** day **14**
 year **1940** hour **8** minute **55 P.M.**

21. I hereby certify that I attended the deceased from **June 24 1940** to **Sept 14 1940**
 that I last saw him alive on **Sept 14 1940**
 and that death occurred on the date and hour stated above.

Immediate cause of death
Pneumonia, Hypostome **2 days**
 Due to **Chronic myocarditis** **3 yrs**
 Due to **Arteriosclerosis - general** **3 yrs**
 Other conditions _____
(Include pregnancy within 3 months of death)

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

Major findings: _____
 Of operations _____
 Of autopsy _____

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? **595**

While at work? _____ (Specify type of place)
 (e) Means of injury _____

23. Signature **Oscar A. Curran** (M. D. or other) **1**

Address **Perryville Mo** Date signed **9-16-40**

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

MOTHER FATHER

922

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

Edward C. Young

Licensed Embalmer No.

21387

P. O. Address

Perryville mo

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. **35984**

Registration District No. **660**

Primary Registration District No. **4296**

Registrar's No. _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

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

3. (a) PRINT FULL NAME

August Bierle

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex **m**

5. Color or race **w**

6. (a) Single, widowed, married, divorced **w**

6. (b) Name of husband or wife _____

6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day

77

11

8

hr. min.

9. Birthplace _____

(City, town, or county)

(State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____

(City, town, or county)

(State or foreign country)

14. Maiden name _____

15. Birthplace _____

(City, town, or county)

(State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____

(Date received local registrar)

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(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 **9** day **14**
year **1940** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19 _____ to _____ 19 _____;
that I last saw h. _____ alive on _____ 19 _____;
and that death occurred on the date and hour stated above.

Immediate cause of death

Pneumonia - Hypostatic

Due to **Chr. Myocarditis**

Due to **arterio sclerosis - general**

Other conditions (Include pregnancy within 3 months of death) **none**

Major findings: Of operations **no operation**

Of autopsy **92C**

Duration

PHYSICIAN

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? _____

While at work? _____

(Specify type of place)

(e) Means of injury _____

23. Signature **Oscar C. Carson** (M. D. or other) _____

Address **Perryville, Mo** Date signed **12-13-40**

SUPPLEMENTAL

