

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

FILED NOV 19 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 34861

Registration District No. 307

Primary Registration District No. 5425

Registrar's No.

1. PLACE OF DEATH: Gasconade
(a) County. Rural, Gasconade Township
(b) City or town. (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1 1/2 miles north of Bay
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 84 years (Specify whether years, months or days)
In this community.

3. (a) PRINT FULL NAME Mrs. Mary Bierwirth
3. (b) If veteran, name war. 3. (c) Social Security No.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Henry Bierwirth 6. (c) Age of husband or wife if alive years
7. Birth date of deceased Feb. 14 1857 (Month) (Day) (Year)

8. AGE: Years 84 Months 7 Days 22 If less than one day hr. min.

9. Birthplace Bay Missouri (City, town, or county) (State or foreign country)

10. Usual occupation Hwf.

11. Industry or business

MOTHER FATHER { 12. Name Fritz Hoelmer 13. Birthplace Germany (City, town, or county) (State or foreign country)
14. Maiden name Katherine Schear 15. Birthplace Germany (City, town, or county) (State or foreign country)

16. (a) Informant Frank Bierwirth (b) Address Bay, Missouri

17. (a) Burial (b) Date thereof 10/8/41 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Paul's Cem. Bay, Hugo H. Blumer

18. (a) Signature of funeral director Hermann, Missouri (b) Address

19. (a) 10-7-41 (b) Mrs. F. B. Meyer (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Gasconade 37
(c) City or town Bay, Mo. Rural (If outside city or town limits, write "RURAL")
(d) Street No. 1 1/2 Miles north of Bay (If rural, give location)
(e) If foreign born, how long in U. S. A. years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Oct day 5-th year 1941 hour 8:15 minute M.

21. I hereby certify that I attended the deceased from May 1941, to Oct 5-th, 1941, that I last saw her alive on Oct 5-th, 1941, and that death occurred on the date and hour stated above.

Immediate cause of death Dyspnea Pneumonia
Due to Fracture Neck femur

Other conditions (Include pregnancy within 3 months of death)

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 037
(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) Means of injury

23. Signature Edward H. Meyer (M.D. or other) Address Hermann, Mo. Date signed 10-7-41

270 (Licensed Embalmer's Statement on Reverse Side)

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.....

Hugo H. Blum

Licensed Embalmer No. 3160

P. O. Address Hermann, Missouri

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.

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1. PLACE OF DEATH:

(a) County Gasconade
(b) City or town Rural
(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

Mary Biermirth

3. (b) If veteran,
name war.....

3. (c) Social Security
No.

4. Sex 7

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 Feb. 14 185
(Month) (Day) (Year)

8. AGE:

Years
84

Months
7

Days
23

(If less than one day
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) (Burial, cremation, or removal)

(b) Date thereof.....
(Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) (Date received local registrar)

(b) (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) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct year 1941 hour..... minute..... M.

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

Immediate cause of death Myocardial infarction
Duration.....

Due to fracture of neck
7 mm. of
Due to fall in home

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....

Of autopsy.....

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) Accident
(b) Date of occurrence July 21-1941
(c) Where did injury occur? Gasconade Co. Mo.
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
at home on farm
While at work? no (Specify type of place) (e) Means of injury fall
23. Signature Howard H. Hearn (M. D. or other)
Address Beverly Date signed 8-6-41

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

SUPPLEMENTARY

