

26380

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

8732

State File No.

FILED APR 6 1944

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 2954

## 1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
 (b) City or town St. Louis, Mo.  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
St. Louis City Hospital  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 13 days  
 (Specify whether  
 In this community unk.  
 years, months or days)

3. (a) PRINT FULL NAME Anton Bieser3. (b) If veteran, name war unk. 3. (c) Social Security No. unk.4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced single6. (b) Name of husband or wife -- 6. (c) Age of husband or wife if alive \_\_\_\_\_ years7. Birth date of deceased unk.  
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day  
74? hr. min.9. Birthplace unk. 9  
(City, town, or county) (State or foreign country)10. Usual occupation unk.11. Industry or business unk.12. Name unk.13. Birthplace unk. 9  
(City, town, or county) (State or foreign country)14. Maiden name unk.15. Birthplace unk. 9  
(City, town, or county) (State or foreign country)16. (a) Informant M. Renard(b) Address St. Louis city hospital17. (a) Antoinette Bieser (b) Date thereof 3-27-44  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation St. Louis18. (a) Signature of funeral director W. Richter(b) Address 3520 Rutherford19. (a) MAR 29 1944 (b) J. J. Budeck  
(Date received) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 12  
 (c) City or town St. Louis 9 N 3  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 1559 So. Broadway  
 (If rural, give location)  
 (e) Citizen of foreign country? ? (Yes or No)  
 If yes, name country 0

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 19th  
year 1944 hour 4:40 minute A. M.21. I hereby certify that I attended the deceased from March 6th  
1944 to March 19th 19 44that I last saw him alive on March 19th 19 44  
and that death occurred on the date and hour stated above.Immediate cause of death \_\_\_\_\_  
Duration \_\_\_\_\_Lobar pneumonia  
Due to \_\_\_\_\_Due to \_\_\_\_\_  
108Other conditions \_\_\_\_\_  
(Include pregnancy within 5 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 \_\_\_\_\_

(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 Frank J. Bueck (M. D. or other) h. a.Address 1515 Lafayette Date signed 3/20/44

(Licensed Embalmer's Statement on Reverse Side)

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

43  
7.39  
K36671

**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 com the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**

818

1003

Registrar's No. 2974

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town \_\_\_\_\_  
(c) Name of hospital or institution: St. Louis City Hospital  
(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: Anton Breeser  
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: Single

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 74 Months \_\_\_\_\_ Days \_\_\_\_\_ 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 (b) Date thereof: 5/11/45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Old St. Peter's Church

18. (a) Signature of funeral director: [Signature]

(b) Address: 4225 S. Kingshighway

19. (a) MAY 11 1945 (b) J. T. Bredeck  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo (b) County \_\_\_\_\_  
(c) City or town: St. Louis  
(If outside city or town limits, write "RURAL")  
Street No.: 1559 S. Broadway  
(If rural, give location)  
(e) Citizen of foreign country \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 19  
year 1945 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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

Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address: 519 West 11th St. St. Louis, Mo. Date signed \_\_\_\_\_

SUPPLEMENTAL

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

Reclaimed from Anatomical Board Joseph Bauer, 4225 S. Kingshighway

