S. No. 2
DM—5-43
v. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 24891

FILED AUG 7 1945

Registration District No. 377 Primary Registration District No. 2002 Registrar's No. 1905

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town University City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 715 Westgate
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 41 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town University City
(If outside city or town limits, write "RURAL")
(d) Street No. 715 Westgate
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Frank Bierman

3. (b) If veteran, name war no

3. (c) Social Security No. 488-10-8405

4. Sex male

5. Color or race white

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

6. (b) Name of husband or wife Anna

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

7. Birth date of deceased April 1, 1891
(Month) (Day) (Year)

8. AGE: Years 54 Months 3 Days 28 If less than one day ..... hr. ..... min.

9. Birthplace Galicia (City, town, or county) Poland (State or foreign country)

10. Usual occupation Commission

11. Industry or business Butter and Eggs, etc.

FATHER
12. Name Max Bierman
13. Birthplace Volhynia (City, town, or county) Russia (State or foreign country)

MOTHER
14. Maiden name Rose Gack
15. Birthplace Volhynia (City, town, or county) Russia (State or foreign country)

16. (a) Informant Evelyn Roth
(b) Address 7141 Tulane

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 7 30 45 (Month) (Day) (Year)
(c) Place: burial or cremation Chesed Shel Emeth

18. (a) Signature of funeral director Berger Memorial
(b) Address 4715 McPherson Avenue

19. (a) 7-31-45 (Date received local registrar) (b) E. G. McGovern M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 29
year 1945 hour 5 minute 45 A.M.

21. I hereby certify that I attended the deceased from ....., 1915, to July 29, 1945
that I last saw him alive on July 27, 1945
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral Haemorrhage	15 min.
Due to Chr. Int. nephritis	20 yrs
Due to Hypertension (Sclerosis)	15 yrs.
Other conditions (Include pregnancy within 3 months of death) 1310.	

Major findings:
Of operations
Of autopsy none

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

23. Signature [signature] (M. D. or other)
Address 610-13 Metropolitan Bldg Date signed 7/29/45

(Licensed Embalmer's Statement on Reverse Side)

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. 1597

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, fact should be so stated above.