S. No. 2
OM—2-43
v. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 6 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 36080

Registration District No. 149 Primary Registration District No. 102 Registrar's No. 4839

1. PLACE OF DEATH:
(a) County Jackson,
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Joseph Hospital O
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 weeks (Specify whether years, months or days)
In this community as above

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 21
(c) City or town Salisbury 2
(If outside city or town limits, write "RURAL")
(d) Street No. - 0
(If rural, give location)
(e) Citizen of foreign country? no. (Yes or No) 1
If yes, name country x

3. (a) PRINT FULL NAME William Biere
3. (b) If veteran, name war no.
3. (c) Social Security No. no.
4. Sex Male O
5. Color or race white
6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife unknown,
6. (c) Age of husband or wife if alive x years
7. Birth date of deceased October (Month) 5 (Day) 1861 (Year)
8. AGE: Years 84 Months 1 Days 17 If less than one day hr. min.
9. Birthplace Missouri (City, town, or county) (State or foreign country)
10. Usual occupation at home, retired
11. Industry or business farmer
MOTHER FATHER
12. Name Christopher Biere 7
13. Birthplace unknown, 7 (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Emgarten
15. Birthplace unknown 4 (City, town, or county) (State or foreign country)
16. (a) Informant Theodore Biere,
(b) Address Salisbury, Missouri
17. (a) removal (Burial, cremation, or removal) (b) Date thereof 11-22-45 (Month) (Day) (Year)
(c) Place: burial or cremation Salisbury, Missouri
18. (a) Signature of funeral director Stine & McClure,
(b) Address 3235 Gillham Plaza, K. C., Mo.
19. (a) 11-24-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 22 year 1945 hour 10:35 minute A. M.
21. I hereby certify that I attended the deceased from Nov 8 1945, to Nov 22 1945, that I last saw him alive on Nov 22 1945, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Chronic Hypertrophic Exhaustion (Heart Failure)	
Due to Uremia	
Due to Prostatic Obstruction 3 yr	
Other conditions (Include pregnancy within 3 months of death) Senile Prostatic Hypertrophy	
Major findings: Of operations (Transurethral Resection 11/14/45)	
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 [illegible] (M. D. or other)
Address 1019 [illegible] Date signed 11/14/45

(Licensed Embalmer's Statement on Reverse Side)

1019

Dr. Lee Hoffman Graf Billy Dat

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 [signature]

Licensed Embalmer No. 1415

P. O. Address 19 C M

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.