

FEDERAL BUREAU OF INVESTIGATION # 88459 MISSOURI DIVISION OF HEALTH
National Office of Vital Statistics
STANDARD CERTIFICATE OF DEATH

State File No. 27515
Registrar's No. 7178

FILED AUG 28 1948
Registration District No. 318

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County.....
(b) City or town..... St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution.....
St. Louis City Hospital-Max C. Starkloff
(If not in hospital or institution, write street number and location)
Memorial
(d) Length of stay: In hospital or institution.....
(Specify whether years, months or days)

3. (a) PRINT FULL NAME..... Lottie Biemann

3. (b) If veteran, name war..... None 3. (c) Social Security No. None

4. Sex..... Female 5. Color or race..... White 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..... October 24, 1875
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
72 9 20 hr. min.

9. Birthplace..... Unknown Germany 4
(City, town, or county) (State or foreign country)

10. Usual occupation..... At home

11. Industry or business.....

12. Name..... Henry Biemann
13. Birthplace..... Unknown Germany 4
(City, town, or county) (State or foreign country)
14. Maiden name..... Catherine Wealing
15. Birthplace..... Unknown Germany 4
(City, town, or county) (State or foreign country)

16. (a) Informant..... Herman E. Biemann
(b) Address..... 8646 Trafford Lane

17. (a) Burial (b) Date thereof..... 8/16/48
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director..... Math. Hermann & Son, Inc.

(b) Address..... 2161 East Fair Ave

19. (a) AUG 16 1948 (b) J. F. Brubaker
(Date received local registrar) (Registrar's signature)

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... Missouri (b) County..... 000
(c) City or town..... St. Louis 17
(If outside city or town limits, write "RURAL") 9
(d) Street No. 4205 Clay Ave 0
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... August day..... 13th
year..... 1948 hour..... 5 minute..... 15 P. M.

21. I hereby certify that I attended the deceased from..... 8-2-48
....., 19....., to..... 8-13-48, 19.....
that I last saw him..... alive on..... 8-13-48, 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death..... Thrombosis of
left lenticulostriate artery
manifested by hemiplegia and coma 11 DAYS
Due to..... Arteriosclerosis - Years
Cardiac failure 2 DAYS
Due to..... ARTERIOSCLEROTIC HEART
DISEASE

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

Major findings:
Of operations.....

Of autopsy..... SAME

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)

23. Signature..... Walter B. Miller (M. D. or other) M. D.
Address..... 1515 Lafayette Avenue Date signed..... 8-14-48

PHYSICIAN

Underline the cause of which death should be charged statistically.

WRITE PLAINLY—USING CAPITALS

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.....
.....
working under my personal supervision.

Signed..... *Glen W. Hay* Registered Apprentice No.
Licensed Embalmer No. *372*
P. O. Address *2161 E. Fair*

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.