

FILED OCT 26 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

35145

State File No. ....

8980

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. ....

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Illinois</b> b. COUNTY <b>St. Clair</b>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. CITY <b>Signal Hill</b> OR TOWN <b>E. St. Louis</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Mo. Baptist Hospital</b>		e. STREET ADDRESS (If rural, give location) <b>32 Woodlawn</b> <span style="float: right;">\$12<sup>00</sup> 4</span>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>ALFRED</b> b. (Middle) <b>LEVAN</b> c. (Last) <b>BISTON</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Oct. 2, 1954</b>		
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>May 24, 1904</b>	9. AGE (In years last birthday) <b>50</b>	IF UNDER 1 YEAR Months Days IF UNDER 12 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work usually during most of year. If retired, so state.) <b>General Manager</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Scherer Frt. Lines</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Philadelphia, Penn.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13a. FATHER'S NAME <b>Ferdinand A. Biston</b>		13b. MOTHER'S MAIDEN NAME <b>Elizabeth Moyer</b>	
14. NAME OF HUSBAND OR WIFE <b>Stella Biston</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes, give year or dates of service) <b>WW 2</b>		16. SOCIAL SECURITY NO. <b>328-08-2990</b>	
17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Stella Biston, 32 Woodlawn</b>		18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary disease.</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Adeno carcinoma Left Kidney</b> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Polycythemia</b>	
19a. DATE OF OPERATION <b>Oct 1/54</b>		19b. MAJOR FINDINGS OF OPERATION <b>adeno carcinoma Left Kidney</b>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>180X</b>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>Sept 10, 1954</b> , to <b>Oct 2, 1954</b> , that I last saw the deceased alive on <b>Oct 3, 1954</b> and that death occurred at <b>3:02 p.m.</b> , from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) <b>Walter Schaller MD</b>		23b. ADDRESS <b>505 Humboldt Bldg</b>		23c. DATE SIGNED <b>Oct 4/54</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <b>Oct. 4, 1954</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Walnut Hill Cemetery</b>	
24d. LOCATION (City, town, or county) (State) <b>Belleville, Ill.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Alexander &amp; Sons</b>		ADDRESS <b>6175 Delmar</b>	
DATE REC'D BY LOCAL REG. <b>OCT 4 1954</b>		REGISTRAR'S SIGNATURE <b>Carl Smith</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	

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

(Licensed Embalmer's Statement on Reverse Side)

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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 ....., Student Embalmer No. .... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *jos. E. McCulloch*.....

Licensed Embalmer No. *246*.....

P. O. Address *617 1/2 St.*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.