

FILED SEP 17 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33239

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **8277**

S. 300
1-57
D
All diseases in Part I must be causally related.
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Missouri b. COUNTY St. Francois	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN Farmington	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Lukes Hos.		d. STREET ADDRESS (If outside, give location) 31 30 Oak St.	
3. NAME OF DECEASED (Type or print) First Genevieve Middle Bieser Last Bieser		4. DATE OF DEATH Month August Day 25 Year 1957	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 26, 1896
9. AGE (In years, last birthday) 61		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) attendant	11. BIRTHPLACE (City and state or country) Coffman, Missouri
12. CITIZEN OF WHAT COUNTRY? U. S.		13. FATHER'S NAME Anthony Bolle	
13b. MOTHER'S MAIDEN NAME Mary Vogt		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 190-24-9746	
17. INFORMANT Leo Bieser		Address Kirkwood, Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Monocytic Leukemia			INTERVAL BETWEEN ONSET AND DEATH 3 weeks
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 2042			
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20f. CITY, TOWN, OR LOCATION Farmington, Mo.	
21. I attended the deceased from 8/23/57 to 8/25/57 and last saw her alive on 8/25/57 Death occurred at 2:50 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) John B. Shopleigh M.D.	
22b. ADDRESS 3720 Washington		22c. DATE SIGNED 9/3/57	
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE Aug. 26.	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) Farmington, Mo.	
24. FUNERAL DIRECTOR Cozean		ADDRESS Farmington, Mo.	
25. DATE RECD. BY LOCAL REG. SEP 4 '57		26. REGISTRAR'S SIGNATURE J. Carl Smith MD	

SEP 18 1957

JUN 4 1957

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 *W. Homer W. Dritz*

Licensed Embalmer No. *3882*
P. O. Address *St. Louis*

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.