

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

1. PLACE OF DEATH

County St. Louis
Township St. Louis
City St. Louis

Registration District No. 791

Primary Registration District No. 1003

File No. 3117

Registered No. 712

St.

Ward

2. FULL NAME

Henry Albert Biri
(a) Residence, No. Esther, Mo. St. 12 Ward. Esther Mo.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U.S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Married

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

Ellen Biri

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

12-24-1885

7. AGE

YEARS

MONTHS

DAY

IF LESS than 1
day, ____ hrs.
or ____ min.

41

25

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Black Smith

(b) General nature of industry, business, or establishment in which employed (or employer)

St. Joseph Lead Co.

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Missouri

10. NAME OF FATHER

Henry Biri

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Mo.

12. MAIDEN NAME OF MOTHER

Esther E. Calverly

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Don't know

14.

INFORMANT
(Address)

Madison Biri
Flat Rm MO.

15.

FILED

JAN 21 1927

Max B. Starck

REGISTER

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

1-19

1927

17.

I HEREBY CERTIFY, That I attended deceased from

1-16, 1927, to 1-19, 1927

that I last saw him alive on 1-19, 1927, and that death occurred, on the date stated above, at 10:57 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

30
22 Tuberculosis of left kidney

14610

CONTRIBUTORY
(SECONDARY)

Embolism

(duration) 1 yrs.

mos.

ds.

Brain

Contribution to lung or

Immediate

(duration) 1 yrs.

mos.

ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH...

Esther, Mo.

3 DID AN OPERATION PRECEDE DEATH?

Cystoscopy, prostatic 1-27

WAS THERE AN AUTOPSY?

No

WHAT TEST CONFIRMED DIAGNOSIS?

Clinical findings + X-ray

(Signed)

Myron W. Davis

M. D.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Flat Rm MO.

Jan 20 1927

20. UNDERTAKER

ADDRESS

Raymond L. Caldwell
Flat Rm MO.

10

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County.....

Registration District No.....

791

File No.....

Township.....

Primary Registration District No.....

1003

Registered No.....

City.....

St.....

Ward.....

2. FULL NAME

(a) Residence. No.....

St.....

Ward.....

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

da.

How long in U.S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR
DIVORCED (write the word)

M

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1
day, ____ hrs.
or ____ min.

8. OCCUPATION OF DECEASED

- (a) Trade, profession, or
particular kind of work.....
(b) General nature of industry,
business, or establishment in
which employed (or employer).....
(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN).....

(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....

(STATE OR COUNTRY)

14.

INFORMANT

(Address)

15.

FILED

19. *Mar 6 Starveoff*

REGISTERED

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

Jan 19 1927

17.

I HEREBY CERTIFY, That I attended deceased from.....

..... to....., 19.....
that I last saw him..... alive on....., 19....., and that
death occurred, on the date stated above, at.....

THE CAUSE OF DEATH WAS AS FOLLOWS:

CONTRIBUTORY
(SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?.....

DID AN OPERATION PRECEDE DEATH?.....

DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed).....

M. D

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state
(1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or
HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

1-20-1927

20. UNDERTAKER

ADDRESS

N. B.—If of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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