

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

Do not use this space.

1528

PLACE OF DEATH

County St. Louis Registration District No. 784
 Township St. Ferdinand Primary Registration District No. 6030
 City F. St. Louis (No. R. 34 Parker Rd.) St. _____ Ward _____

File No. 38010
 Registered No. _____
 St. _____ Ward _____

2. FULL NAME

Marguerite J. Niehoff
 (a) Residence. No. R. 34 Parker Rd. St. _____ Ward _____
 (Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 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 Joseph H. Niehoff

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 26 = 1883

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
43 11 28.

8. OCCUPATION OF DECEASED House wife
 (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) Florissant
 (STATE OR COUNTRY) Mo.

10. NAME OF FATHER Henry Germinig

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Florissant
 (STATE OR COUNTRY) Mo.

12. MAIDEN NAME OF MOTHER Mary Stroer

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Florissant
 (STATE OR COUNTRY) Mo.

14. INFORMANT Joseph H. Niehoff
 (Address) Florissant Mo.

15. FILED 12-25 1927 O. Schuch REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 24th 1927

17. I HEREBY CERTIFY That I attended deceased from Dec 19th 1927 to Dec 24th 1927 that I first saw him alive on Dec 24th 1927, and that death occurred, on the date stated above, at 110 A.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

myocarditis sup. acute

CONTRIBUTORY (SECONDARY) Exophthalmic Goiter
6 month duration (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH? no
 DID AN OPERATION PRECEDE DEATH? no DATE OF _____
 WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? clinical
 (Signed) Ray Johnson M. D.
12/24/27 (Address) Florissant Mo.

*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 Florissant Mo. Laurel Hill DATE OF BURIAL Dec 27th 1927

20. UNDERTAKER Aug Brockland & Co ADDRESS 1421 N. 9th St

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

