

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

Do not use this space.

29377

1. PLACE OF DEATH

County..... Registration District No. 1091
 Township..... Primary Registration District No. 1008
 City St. Louis Mo. (No. 3856 Sullivan Ave. St. _____ Ward)

File No. _____
 Registered No. 8534

2. FULL NAME Albert Niehaus, Jr.

(a) Residence No. 3856 Sullivan Ave. St. 10 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. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male.</u>	4. COLOR OR RACE <u>White.</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Infant.</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>6/20/29</u>		
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) St. Louis Mo.
 (STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Albert Niehaus.

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

12. MAIDEN NAME OF MOTHER Verna Mauer.

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

14. INFORMANT Albert Niehaus
 (Address) 3858 Sullivan Ave

15. FILED _____ 19 _____
W. H. Stanley
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8/20/1929

17. I HEREBY CERTIFY, That I attended deceased from 8:20-29
7:59 AM 8-20, 1929, to 1:00 PM 8-20, 1929
 that I last saw him alive on 8:30 AM 8-20-29, and that death occurred, on the date stated above, at One m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Premature Birth.

15 / 16 / 17 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 16 / 17
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, at place of birth

(1) DID AN OPERATION PRECEDE DEATH? no DATE OF none

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical Examination
 (Signed) Dr. G. G. O'Connell, M. D.
8-20, 1929. (Address) 3557 Grand St.

*State the DISEASE CAUSING DEATH, of infectious 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
Wolk Hill Cemetery. 8/21/29 19

20. UNDERTAKER ADDRESS
Provost Lued Co 3710 N. Grand

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.

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

