

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.

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

Do not use this space.

28306
8158

1. PLACE OF DEATH

County..... Registration District No. 791
Township..... Primary Registration District No. 1003
City Athena Mo (No. 4316 & Grace) St. _____ Ward _____

2. FULL NAME

Conrad J. Nies
(a) Residence. No. 4316 Grace St. 15 Ward _____
(Usual place of abode)
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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male
4. COLOR OR RACE white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 5 - 1867
7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
63 2 9
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Clerk
(b) General nature of industry, business, or establishment in which employed (or employer) Clerical
(c) Name of employer Athena Transfer Co.

9. BIRTHPLACE (CITY OR TOWN) Athena
(STATE OR COUNTRY) Mo

10. NAME OF FATHER John A Nies
11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
(STATE OR COUNTRY) Germany
12. MAIDEN NAME OF MOTHER Katherine Regel
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
(STATE OR COUNTRY) Germany

14. INFORMANT Katherine Nies
(Address) 4316 Grace Ave

15. FILED HUG 15 1930 Max C. HUBBARD REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-14 1930

17. I HEREBY CERTIFY, That I attended deceased from July 1930 to Aug 14 1930 that I last saw him alive on Aug 14 1930 and that death occurred, on the date stated above, at 11 25 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Myocarditis Chronic
131
930

CONTRIBUTORY (SECONDARY) Nephritis Chronic
(duration) yrs. 1 mos. 1 ds.

18. WHERE WAS DISEASE CONTRACTED _____
IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? No DATE OF _____
WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS Examination of tissues
(Signed) James H. Quator M. D.
815 1930 (Address) 3400 California Ave

*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 Bellefontaine Cem DATE OF BURIAL 8-16 1930

20. UNDERTAKER Weich Bros 2201 So Grand ADDRESS

