

JUL 12 1939 **791**
Registration District No. 1008

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Alexian Brothers Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 Wks
In this community unknown (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 215 1/2 Market St.
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years

3. (a) PRINT FULL NAME 569 Joseph Niemeyer

8. (b) If veteran, name war Spanish American 8. (c) Social Security None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife If _____ years

7. Birth date of deceased July 4, 1869
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
69 11 8 _____ hr. _____ min.

9. Birthplace St. Rose Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business _____

12. Name unknown

13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name unknown
15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Hospital Information

(b) Address 39 33 S. Broadway

17. (a) Burial (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Iola, Kansas

18. (a) Signature of funeral director Wesley Brea

(b) Address 2201 S. Grand

19. (a) JUN 15 1939 (b) J. J. [Signature]
(Date of death) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 12
year 1939 hour 4 minute 0 P. M.

21. I hereby certify that I attended the deceased from May 19, 1939 to June 12, 1939; that I last saw him alive on June 12, 1939 and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Infarction
Due to Cystostomy and urethrotomy
Due to Arteriosclerosis
no stones
Other conditions My anemia
(Include pregnancy within 3 months of death)

Duration

4 days
5 1/2 hrs
16 1/2 hrs

PHYSICIAN

Major findings: Arteriosclerosis
Of operations _____
Of autopsy non

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) no
(b) Date of occurrence _____
(c) Where did injury occur? _____
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature J. J. [Signature] (M. D. or other) _____
Address 2201 S. Broadway Date signed 6/14/39

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

Rev. 8-17-39
U. S. G. P. 1 X1951

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.....

.....
working under my personal supervision.

Registered Apprentice No.

Signed *Henry A. Stewart*

Licensed Embalmer No. 3722

P. O. Address 412 Duchouquette St.

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 this body is not embalmed, above space should be left blank.