

AUG 9 1939

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

25430

Do not use this space.

1. PLACE OF DEATH

(a) County Cole Registration District No. 213
(b) Township _____ Primary Registration District No. 3014 Registered No. 165
(c) City Jefferson City (d) Street No. 210 Dawson St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred _____ yrs. mos. ds. (f) How long in U. S., if of foreign birth? _____ yrs. mos. ds.

2. PRINT FULL NAME Joseph Nierman

(a) Residence, No. 210 Dawson St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 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 Mrs. Anna Nierman

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 2, 1860

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
78 8 14

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired
9. Industry or business in which work was done, as saw mill, bank, etc. Cabinet Maker.
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Cincinnati, Ohio13. NAME Joseph Nierman14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany15. MAIDEN NAME Unknown16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown17. INFORMANT Mrs. Anna Nierman
(ADDRESS) 210 Dawson St. J.C. Mo.18. GENERAL RECORDS REMOVAL
PLACE St. Louis, Mo. DATE July 17, 193919. FUNERAL DIRECTOR (NAME) John F. Heinrichs
(ADDRESS) Jefferson City, Mo.20. FILED 7/17 1939 J. U. Bedford M.D.
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 16, 1939

22. I HEREBY CERTIFY That I attended deceased from July 1937 to July 16, 1939
I last saw him alive on July 16, 1939. Death is said to have occurred on the date stated above at 12:07 a.m.
The principal cause of death and related causes of importance were as follows:

Pneumonia
Hypostatic Date of onset 7-14-39

Other contributory causes of importance:
Old Hemiplegia
Hypertension July 1937

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify _____
(Signed) Julian A. Osmond, M.D.
(Address) Jefferson City - Mo.

111

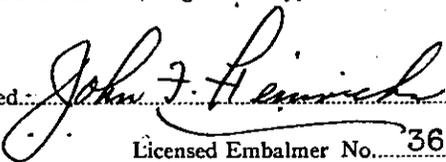
STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

John F. Heinrichs

Registered Apprentice No.....

working under my personal supervision.

Signed: 

Licensed Embalmer No. **3655**

P. O. Address **Jefferson City, Mo.**

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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

25-430
Do not use this space.

1. PLACE OF DEATH

(a) County Bole Registration District No. 213
 (b) Township _____ Primary Registration District No. 3014 Registered No. 165-
 (c) City Jefferson (d) Street No. _____ St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Joseph Nierman

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

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.
78 8 14

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
 9. Industry or business in which work was done, as saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

FATHER 13. NAME _____

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

MOTHER 15. MAIDEN NAME _____

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE _____

19. FUNERAL DIRECTOR (ADDRESS) _____

20. FILED _____ 19 _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-16-1939

22. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19____.

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Pneumonia
Supportatic
g.f.h.

(Other contributory causes of importance: _____)

Old Hemiplegia
Hypertension
Hemiplegia due to old cerebral

Name of operation hemiarthrectomy Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) Julian A. Osborn, M. D.
 (Address) Jefferson City Mo

Local Registrar.

SUPPLEMENT

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

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHOULD BE CAREFULLY SUPPLIED. AGE should be stated EXACTLY. PHYSICIAN'S SIGNATURE

S-25430. 1939