

FILED MAY 15 1941

State File No.

Registration District No. 243

Primary Registration District No. 5365

Registrar's No.

1. PLACE OF DEATH: DeKalb  
 (a) County DeKalb  
 (b) City or town Weatherby Mo. P. R.  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: /  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
 In this community Three years.  
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County DeKalb 32  
 (c) City or town Weatherby Mo. P. R. 0  
 (If outside city or town limits, write "RURAL") 0  
 (d) Street No. 0  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME Truman Franklyn NeiderhAuser

MEDICAL CERTIFICATION

3. (b) If veteran, No name war  
 3. (c) Social Security No. No.

20. DATE OF DEATH: Month April day 24.  
 year 1941 hour 11 minute 30 P. M.

4. Sex Male 5. Color or race white  
 6. (a) Single, widowed, married, divorced Married  
 6. (b) Name of husband or wife Lola Mae 6. (c) Age of husband or wife if alive 33 years  
 7. Birth date of deceased Oct 17 1905  
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Apr 24 1941  
 that I last saw h. alive on \_\_\_\_\_ 19\_\_\_\_  
 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	35	6	7	hr. min.

Immediate cause of death: Examined after death probably Coronary Thrombosis

9. Birthplace Maysville Mo. P. R.  
 (City, town, or county) (State or foreign country)

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

10. Usual occupation Farmer  
 11. Industry or business Same

Other conditions (Include pregnancy within 3 months of death) Influenza 94

12. Name Jake Neiderhouser  
 13. Birthplace Switzerland  
 (City, town, or county) (State or foreign country)

Major findings: Of operations none

14. Maiden name Allie M. Steiner  
 15. Birthplace Amity Mo. P. R.  
 (City, town, or county) (State or foreign country)

Of autopsy none

16. (a) Informant Jake Neiderhouser.  
 (b) Address Amity Mo. R. R.

22. If death was due to external causes, fill in the following:  
 (a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
 (b) Date of occurrence \_\_\_\_\_

17. (a) Burial (b) Date thereof 4.27.1941  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(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? 230

(c) Place: burial or cremation Maysville Mo.

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

18. (a) Signature of funeral director R. C. Toppert  
 (b) Address King City Mo.

23. Signature H. Paul Surrye (M.D. or other) 20  
 Address Maysville Date signed 4/27/41

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
 (Date received local registrar) (Registrar's signature)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

**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.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed *R. H. Taggart*

Licensed Embalmer No. 2567

P. O. Address King City Mo.

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 14399

Registration District No. 263

Primary Registration District No. 5365

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County DeKalb  
(b) City or town Adams T.P.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME Freeman Franklin Neiderhauer  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

8. AGE: Years 35 Months 8 Days 7 If less than one day \_\_\_\_\_ hr \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_ (State or foreign country)

15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

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

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) June 18-41 (b) James Fitzgerald  
(Data received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

20. DATE OF DEATH: Month Apr day 24  
year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw h \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(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 H. Paul Sarge (M. D. or other) \_\_\_\_\_  
Address Maysville Mo Date signed \_\_\_\_\_

SUPPLEMENTAL

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-14399