1-10-39
-17-39
X21492

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 6575

FILED MAR 2 1942

Registration District No. 2 Primary Registration District No. 5413 Registrar's No.

1. PLACE OF DEATH:
(a) County: Franklin
(b) City or town: Union Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community 79 yrs.

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

3. (a) PRINT FULL NAME: Chris Fred William Niermeyer
3. (b) If veteran, name war: ✓
3. (c) Social Security No.: ✓
4. Sex: Male
5. Color or race: White
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Minnie Niermeyer
6. (c) Age of husband or wife if alive: 77 years
7. Birth date of deceased: February (Month) 5th (Day) 1863 (Year)

8. AGE: Years 79 Months 11 Days 26 If less than one day hr. min.

9. Birthplace: Union (City, town, or county) Mo. (State or foreign country)
10. Usual occupation: Farmer
11. Industry or business:
12. Name (Father): John F. Niermeyer
13. Birthplace (Father): Germany (City, town, or country) (State or foreign country)
14. Maiden name (Mother): Charlotta Holscher
15. Birthplace (Mother): Germany (City, town, or country) (State or foreign country)
16. (a) Informant: E. Nutchum
(b) Address: Beaufort, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/4/1942 (Month) (Day) (Year)
(c) Place: burial or cremation: St. John Cemy.
18. (a) Signature of funeral director: E. F. Oltman
(b) Address: Union Mo.
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 1st year 1942 hour 6 minute 40 P.M.
21. I hereby certify that I attended the deceased from Sept. 31, 19 to 2-1, 19 42 that I last saw him alive on 2-1, 19 42 and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral Hemorrhage — Duration: 5 days.
Due to: Hypertension
Due to:
Other conditions (Include pregnancy within 3 months of death): Endocarditis
Major findings: Of operations: Of autopsy: 830

PHYSICIAN — 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):
(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? (Specify type of place)
While at work? (e) Means of injury:
23. Signature: F. M. Leury (M. D. or other) M.D.
Address: Union Mo Date signed 2-2-42

(Licensed Embalmer's Statement on Reverse Side)

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 E. F. Oltmann

Licensed Embalmer No. 1686

P. O. Address Union, Mo

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

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

S. No. 2B
M—8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 6575.

Registration District No. 296 Primary Registration District No. 5413 Registrar's No.

1. PLACE OF DEATH:
(a) County: Franklin
(b) City or town: Rural
(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 years, months or days)
In this community

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

3. (a) PRINT FULL NAME: Chris H. W. Niermeyer
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: Feb 5 1863 (Month) (Day) (Year)

8. AGE: Years 79 Months 11 Days 26 If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) Feb-2-42 (Date received local registrar) (b) Conrad A. Rieger (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day year 1942 hour minute M.
21. I hereby certify that I attended the deceased from 19 to 19; that I last saw him alive on 19; and that death occurred on the date and hour stated above.

Immediate cause of death — Duration
Due to
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations
Of autopsy

PHYSICIAN
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)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(b) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY