

No. 2-1
-5-43
-17-39

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 1 1944

THE STATE BOARD OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH

State File No. 12146

Registration District No. 317

Primary Registration District No. 3063

Registrar's No. 745

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Clayton
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Louis County Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 days
(Specify whether

In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis 96

(c) City or town Pine Lawn
(If outside city or town limits, write "RURAL") 0

(d) Street No. 6200 Glenn
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Julius Niere

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 Wid.

6. (b) Name of husband or wife Maggie Niere (Dec.)

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased August 4, 1870
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>73</u>	<u>7</u>	<u>20</u>	hr. _____ min.

9. Birthplace Ellisville Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business _____

MOTHER FATHER

12. Name William Niere

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

14. Maiden name Unknown Hinsel

15. Birthplace Unknown Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Joseph Niere

(b) Address R R 4 14 Lappington Mo

17. (a) Burial (b) Date thereof 3-29-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St Paul Am

18. (a) Signature of funeral director Louis H Bopp

(b) Address Keokuk Mo

19. (a) MAR 28 1944 (b) E S McEwan
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3-24-44 day _____
year _____ hour 7:40 minute _____ A. M.

21. I hereby certify that I attended the deceased from 3-17-44, 19____, to 3-23-44, 19____,
that I last saw him alive on 3-23-44, 19____,
and that death occurred on the date and hour stated above.

Immediate cause of death
Diabetes mellitus
Diabetic gangrene of left
foot

Duration	<u>8 yrs</u>
Due to	<u>2 mos.</u>
Due to	_____
Other conditions	<u>Inter trochanteric fracture, left 3 days</u>

(Include pregnancy within 3 months of death)

Major findings:
Of operations none

Of autopsy none

ADDITIONAL SUPPLEMENTARY INFORMATION

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external cause, state the following:
(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence 118

(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 OV

23. Signature James G. Owen, M.D. (M. D. or other) _____

Address 601 Brentwood Blvd Clayton Date signed 3-25-44

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

APR 7 1947

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..... *Felix Demand*

Licensed Embalmer No. *3034*

P. O. Address. *Kirkwood 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, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 317Primary Registration District No. 3063Registrar's No. 745

1. PLACE OF DEATH:

- (a) County St. Louis
 (b) City or town Clayton
 (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 NAMEJulius Mace

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 w

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

7. Birth date of deceased aug 4 (Month) (Day) (Year)

8. AGE: Years 73 Months 7 Days _____ min. (If less than one day)

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 _____

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

16. (a) Informant _____

- (b) Address _____

17. (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date 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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March 20 24
 year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____;

that I last saw him _____ alive on _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death Diabetic mellitus Duration _____

Diabetic gangrene of

left foot

Due to _____

Due to _____

Other conditions: Enter fracture left 3 day PHYSICIAN
 (Include pregnancy within 3 months of death)

Major findings: PHYSICIAN

Of operations: ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Of autopsies: 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) Accident

(b) Date of occurrence 3-21-44

(c) Where did injury occur? Clayton, St. Louis, Mo. (City & town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? In hospital room

While at work? _____ (e) Means of injury Fell

23. Signature James G. Owen (M. D. or other) M. D.

Address 601 Brentwood, Clayton Date signed 4-7-44

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

SUPPLEMENTAL INFORMATION REQUESTED

APR 5 1944

File

12146