

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

FILED NOV 30 1944

318

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No.

Primary Registration District No. 1003

Registrar's No. 9772

1. PLACE OF DEATH:

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 17
(c) City or town St. Louis,
(If outside city or town limits, write "RURAL")
(d) Street No. 4937 Pershing Ave.,
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country U

3. (a) PRINT FULL NAME Albert W. Niedringhaus,

3. (b) If veteran, name war None 3. (c) Social Security No. 330-18-0842

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

6. (b) Name of husband or wife Agnes D. Niedringhaus 6. (c) Age of husband or wife if alive 68 years

7. Birth date of deceased May 24, 1869
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
<input checked="" type="checkbox"/>	75	5	20	hr. min.

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

10. Usual occupation Mgr. Granite City Steel Company.

11. Industry or business
12. Name Wm. F. Niedringhaus,
13. Birthplace Germany,
(City, town, or county) (State or foreign country)
14. Maiden name Mary Bittner,
15. Birthplace St. Louis, Missouri,
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. A. W. Niedringhaus,
(b) Address 4937 Pershing Ave.

17. (a) Burial (b) Date thereof 11/18/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bellefontaine Cem.

18. (a) Signature of funeral director Wagoner Mortuary,
(b) Address 4161 Lindell Blvd.

19. (a) NOV 17 1944 (b) J. J. [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 14
year 1944 hour 8 minute a. M.

21. I hereby certify that I attended the deceased from Sept 13
1944 to Nov 14 1944;

that I last saw him alive on Nov 13 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary thrombosis Duration 3 months

Due to Coronary thrombosis

Due to JH
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)
(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 Harriet B. Grant (M. D. or other)
Address 114 N Taylor Ave. Date signed 11/15/44

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 *Melvin J. Kemper*

Licensed Embalmer No. *4052*

P. O. Address *4005 Lexington*

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.