

FILED DEC 9 1944 318

1003

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registrar's No. 10168

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. Luke's Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution. 16 yrs 3 mos.  
(Specify whether  
In this community Lifetime  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis  
(c) City or town Clayton St. Luke's Hospital  
(If outside city or town limits, write "RURAL")  
(d) Street No. 17 Carrowald Drive  
(If rural, give location) 12  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME William J. Niggeman

3. (b) If veteran, name war. no 3. (c) Social Security None

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

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

7. Birth date of deceased August 11 1878  
(Month) (Day) (Year)

8. AGE: Years 66 Months 3 Days 17 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Retired, V. P. Coal Co.

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

12. Name Robert Niggeman  
13. Birthplace Germany  
(City, town, or county) (State or foreign country)

14. Maiden name Mary Ann Gartside  
15. Birthplace St. Louis Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant Grace D. Niggeman  
(b) Address 17 Cariswold Drive

17. (a) Burial (b) Date thereof 11 29 44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bellefontaine

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

19. (a) Nov. (b) J. F. Brueck  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 28  
year 1944 hour 7 minute 30 A. M.

21. I hereby certify that I attended the deceased from March 1938  
19\_\_\_\_, to Nov. 28 1944;  
that I last saw him alive on Nov. 27 1944;  
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary thrombosis Duration 5 weeks  
Due to generalized arterio-sclerosis 17 yrs.  
chr. myocarditis 17 yrs.

Other conditions Rt hemiplegia (apophytic) 17 yrs.  
(Include pregnancy within 3 months of death)

Major findings: 93 PHYSICIAN \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
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 H. S. Newman (M. D. or other) M.D.  
Address 3720 Washington Date signed 11/28/44

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

MOTHER FATHER

NOV 29 1944

MAY 28 1945

**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

*Novell B. Frohwitter*

Licensed Embalmer No.

*3694*

P. O. Address

*416 Lindell Blvd*

**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.**