

U.S. No. 2
FORM-5-43
Rev. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **15443**
Registrar's No. **4150**

FILED MAY 21 1945
Registration District No. **818**

Primary Registration District No. **1003**

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

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:
Good Samaritan Home - 4500 Washington
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2 years 5**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **000**
(c) City or town **St. Louis** **17 12**
(If outside city or town limits, write "RURAL")
(d) Street No. **Good Samaritan Home 4500 Washington**
(If rural, give location)
(e) Citizen of foreign country? **0** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Louis Niere**
(b) If veteran, name war **None**
(c) National Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **May** day **8th**
year **1945** hour **11:00** AM minute _____ M.

4. Sex **Male**
5. Color or race **White**
6. (a) Single, widowed, married, divorced **Widow**
6. (b) Name of husband or wife **Augusta Niere nee Heidemann**
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **July 16, 1863**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **15** 19**45** **May 8** 19**45**
that I last saw him alive on **May 7** 19**45**
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
81 9 22 hr. min.

Immediate cause of death **Chronic interstitial nephritis**
Due to _____

9. Birthplace **Unknown Mo. 1**
(City, town, or county) (State or foreign country)
10. Usual occupation **Retired**

Other conditions **131 a hyperthyroidism of prostate**
(Include pregnancy within 9 months of death)
Due to _____

11. Industry or business
12. Name **Frederick Niere**
13. Birthplace **Unknown Germany 1**
(City, town, or county) (State or foreign country)
14. Maiden name **Unknown**
15. Birthplace **Unknown Germany 1**
(City, town, or county) (State or foreign country)

Major findings:
Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant **Oliver F. Niere**
(b) Address **5508 Fairridge Ave**
17. (a) **Burial** (b) Date thereof **5/11/45**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Friedens Cemetery**
18. (a) Signature of funeral director **Math Hermann & Son**
(b) Address **2161 East Fair Ave**
19. (a) **MAY 10 1945** (b) **J. F. Bredbeck**
(Date received local registrar) (Registrar's signature)

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 **J. F. Bergman** (M. D. or other) **MD**
Address **2720 Washington** Date signed **5/9/45**

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 *Gustav W. Dietz*

Licensed Embalmer No. *4329*

P. O. Address *St. Louis, 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.