

**FILED** AUG 2 1945  
Registration District No. 82

Primary Registration District No. 3017

State File No. ....

Registrar's No. 72

1. PLACE OF DEATH:  
(a) County Cooper  
(b) City or town Boonville  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Home-808-Spring St 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution.....  
In this community 80 years. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo (b) County Cooper  
(c) City or town Boonville  
(If outside city or town limits, write "RURAL")  
(d) Street No. 808-Spring Street  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME Mike Neckermann  
3. (b) If veteran, name war ✓  
3. (c) Social Security No. ✓

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month July day 4  
year 1945 hour 12:25 AM minute ..... M.

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 Nov 16 - 1856  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from May 4, 1945, to July 4, 1945; that I last saw him alive on May 16, 1945; and that death occurred on the date and hour stated above.

8. AGE: Years 88 Months 7 Days 18  
If less than one day hr. .... min.

Immediate cause of death.....  
Addison Disease  
Duration Several hours

9. Birthplace Germany  
(City, town, or county) (State or foreign country)  
10. Usual occupation Farmed

Due to.....  
Due to.....  
Other conditions Gastritis, etc.  
(Include pregnancy within 3 months of death)  
Senility

MOTHER FATHER  
11. Industry or business.....  
12. Name Andrew Neckermann  
13. Birthplace Germany  
(City, town, or county) (State or foreign country)  
14. Maiden name Berbara Adtsch  
15. Birthplace Germany  
(City, town, or county) (State or foreign country)

Major findings:  
Of operations.....  
Of autopsy.....

16. (a) Informant Mrs Jake Steel  
(b) Address Boonville Mo  
17. (a) Burial (b) Date thereof July 8 - 45  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Wear Creek  
18. (a) Signature of funeral director Woodward Dohler  
(b) Address Boonville Mo  
19. (a) July 5 - 45 (b) Dr Chas. Swaps  
(Date received local registrar) (Registrar's signature)

PHYSICIAN  
Underline the cause to which death should be charged statistically.  
50

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 W.H. Ziegler (M. D. or other) MD  
Address Boonville Mo Date signed 7-5-45

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

RECEIVED

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed \_\_\_\_\_

8-1-45

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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 \_\_\_\_\_

*J. Goodman*

Licensed Embalmer No. 1178

P. O. Address \_\_\_\_\_

*Boonville 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.