

S. No. 2  
12-45  
5-17-39  
1-47070

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED SEP 10 1947**

THE STATE BOARD OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

State File No. **28759**

Registration District No. **365**

Primary Registration District No. **445-2 Wentzville**

Registrar's No. \_\_\_\_\_

**1. PLACE OF DEATH:**  
 (a) County **St Charles**  
 (b) City or town **Wentzville Mo**  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
**Wentzville, Mo**  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution **None** (Specify whether  
 In this community **None** years, months or days)

**3. (a) PRINT FULL NAME** **Martin Niklas**  
 (b) If veteran, name war **Box**  
 (c) Social Security No. **488-07-0657**

**4. Sex** **M** **5. Color or race** **W**  
**6. (a) Single, widowed, married, divorced** **Married**  
**6. (b) Name of husband or wife** **Catherine Niklas**  
**6. (c) Age of husband or wife if alive** **37** years  
**7. Birth date of deceased** **April 10 1907**  
(Month) (Day) (Year)

**8. AGE:** Years **40** Months **4** Days **15**  
 If less than one day **hr. min.**

**9. Birthplace** **New York**  
(City, town, or county) (State of foreign country)

**10. Usual occupation** **Shoe Worker**

**11. Industry or business**

MOTHER FATHER

**12. Name** **Dont know**  
**13. Birthplace** **Germany**  
**14. Maiden name** **Agnes Newmen**  
**15. Birthplace** **Germany**

**16. (a) Informant** **Catherine Niklas**  
**(b) Address** **Wright City, Mo**

**17. (a) Burial** **(b) Date thereof** **Aug 28 1947**  
(Burial, cremation, or removal) (Month) (Day) (Year)

**(c) Place: burial or cremation** **Resurrection Cem. St. Louis Mo**  
**(c) Signature of funeral director** **Wright City, Mo**  
**(b) Address** **Wright City, Mo**

**18. (a) 8-27-47** **(b) Mrs. JESS L. LEWIS**  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State **Mo** (b) County **St Charles 92**  
 (c) City or town **Wentzville, Mo**  
(If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_  
(If rural, give location)  
 (e) Citizen of foreign country? **no** (Yes or No)  
 If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH:** Month **Aug** day **28th**  
 year **1947** hour **5:30** minute **A. M.**

**21. I hereby certify that I am a physician licensed from** **Mo**  
**Aug. 26, 1947**, 19\_\_\_\_, to 19\_\_\_\_;  
 that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
 and that death occurred on the date and hour stated above.

Immediate cause of death **Crushed Chest**  
 Due to **Buss and Truck accident**  
 Due to \_\_\_\_\_  
 Other conditions **17 DE 22**  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
 Of operations \_\_\_\_\_  
 Of autopsy **none**

**22. If death was due to external causes, fill in the following:**  
 (a) Accident, suicide, or homicide (specify) **Accident 92**  
 (b) Date of occurrence **Aug. 26, 1947**  
 (c) Where did injury occur? **Wentzville St Charles Mo**  
(City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?  
**Public place Highway #40 Truck & Buss 3**  
 While at work? **No** (Specify type of place) **(e) Means of injury**

**23. Signature** **Maries Musch...**  
**Address** **Wentzville, Mo** Date signed **8-25-47**

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

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

FEB 24 1948

RECEIVED  
District Health Officer No. 9,  
District File Number 9-9-47  
Date Filed

SEP 11 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 *Julius J. Meburg*  
Licensed Embalmer No. *33660*  
P. O. Address *Wright City, 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.

Registration District No. 305

Primary Registration District No. 4452

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County St Charles  
(b) City or town Wentzville  
(If outside city or town limits, write "RURAL" and name of township)  
(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)

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 \_\_\_\_\_

3. (a) PRINT FULL NAME

Martin Nublar

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 M

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

7. Birth date of deceased April 10 (Month) (Day) (Year)

8. AGE: Years 40 Months 4 Days 4 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

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

MOTHER FATHER

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. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 8/27/1947 (b) Mrs Jess Lewis  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug Day 14 Year 1947 Hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Duration

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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 \_\_\_\_\_ (M. D. or other)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

S-28759