No. 2
1/47
17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

29365

State File No.

FILED SEP 4 1947

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8114

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: Marian Hospital
(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 Missouri (b) County
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 3225a Pennsylvania Ave.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Rosa Niederer
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife George Niederer
6. (c) Age of husband or wife if alive 79 years
7. Birth date of deceased October 9, 1868
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
78	10	15	hr. min.

9. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)
10. Usual occupation Housewife
11. Industry or business
FATHER
12. Name ------Fiferlick
13. Birthplace Bohemia
(City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Don't Know
15. Birthplace Bohemia
(City, town, or county) (State or foreign country)
16. (a) Informant George Niederer
(b) Address 3225a Pennsylvania Ave.
17. (a) Burial (b) Date thereof 8-27-1947
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Hope Mausoleum
18. (a) Signature of funeral director Weick Bro. Und. Co.
(b) Address 2201 S. Grand Bl.
19. (a) (b) J. F. Bredeck
(Date received local registrar) (Registrar's signature)

AUG 26 1947

AUG 26 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 24
year 1947 hour 6 minute 05 P.M.

21. I hereby certify that I attended the deceased from August 1st, 1947, to Aug 24, 1947
that I last saw her alive on Aug 15, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Chr. myocarditis
Due to chr. arterio-sclerosis and senility
Due to
Other conditions None
(Include pregnancy within 3 months of death)
Major findings:
Of operations None
Of autopsy None

Duration

PHYSICIAN
Underline the cause of 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 John R. Daly (M. D. or other) MD
Address 2767 Gravois Date signed Aug 25 1947

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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.....

Licensed Embalmer No. 3722

P. O. Address 2201 S. Grand Bl.

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.