

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **23062**  
**5640**

FILED JUN 20 1953

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MISSOURI</b> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis, Mo.</b>		c. LENGTH OF STAY (In this place) <b>56</b>		c. CITY OR TOWN <b>St. Louis, Mo.</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Lutheran Hospital</b>				e. STREET ADDRESS (If rural, give location) <b>15 4658 Dewey Ave.</b>		<b>21590</b>	
3. NAME OF DECEASED (Type or Print) a. (First) <b>CLARENCE</b>		b. (Middle) <b>EDWARD</b>		c. (Last) <b>NIEHAUS</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>June 4, 1953</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>		8. DATE OF BIRTH <b>Jan. 1, 1897</b>	
9. AGE (In years last birthday) <b>56</b>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 1 YEAR Hours _____ Min. _____		11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis, Mo.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ma intenance</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>hinge mfg.</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>JOHN NIEHAUS</b>		13b. MOTHER'S MAIDEN NAME <b>ANNIE WAGNER</b>		14. NAME OF HUSBAND OR WIFE <b>FLORENCE ZIMMERMANN</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>War I 488-07-7257</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs. Florence Niehaus 4658 Dewey Ave</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  * This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Pulmonary Embolism</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Int. Obstr. Large Bowel</b> DUE TO (c) <b>Carcinoma Sigmoid Colon</b> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Hypertensive Cardis-Vascular Disease; Obesity</b>				INTERVAL BETWEEN ONSET AND DEATH <b>10 min.</b> <b>5 days.</b> <b>?</b>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____		21f. HOW DID INJURY OCCUR? <b>153X</b>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22. I hereby certify that I attended the deceased from <b>6/3</b> , 19 <b>53</b> , to <b>6/4</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>6/4</b> , 19 <b>53</b> , and that death occurred at <b>3:00 Pm.</b> , from the causes and on the date stated above.			
23a. SIGNATURE <b>E. H. Carson, M.D.</b> (Degree or title)		23b. ADDRESS <b>3606 Gravois Ave.</b>		23c. DATE SIGNED <b>6/5/53</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		24b. DATE <b>June 8, 1953</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Concordia Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>	
DATE REC'D BY LOCAL REG. <b>JUN 6 1953</b>		REGISTRAR'S SIGNATURE <b>J. Earl Smith M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Beiderwieden F.H. Inc., 1936 St. Louis, Ave</b>			

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

Dr. Elbert H. Gason  
3606 Gravois Ave

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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 \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision..

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Max L. Warfel

Licensed Embalmer No. 417

P. O. Address St. Louis

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.