

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-007619  
STATE FILE NUMBER

FILED FEB 18 1958

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 1343

300  
-57

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Florissant</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>De Paul Hospital</u>		Length of stay in 1b <u>5 weeks</u>	d. STREET ADDRESS (If outside, give location) <u>Route 1, Box 154</u>		Reside on Form Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Herman</u> Middle <u>G</u> Last <u>Nieland</u>			4. DATE OF DEATH Month <u>Feb</u> Day <u>3</u> Year <u>1958</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 5 1877</u>	9. AGE (In years last birthday) <u>81</u> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Line Foreman (Retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>St. Louis Public Service</u>	11. BIRTHPLACE (City and state or country) <u>Maxville, Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>Gerhardt Nieland</u>		13b. MOTHER'S MAIDEN NAME <u>Anna Margaret Wester</u>		14. NAME OF HUSBAND OR WIFE <u>Mary T. Nieland</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NUMBER <u>493-10-8708</u> <u>unknown</u>		17. INFORMANT Address <u>Miss Josephine Nieland, Rt. Bx 154, Florissant</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction due to coronary thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>36 days</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>420.1</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. Attended the deceased from _____ to _____ Death occurred at _____ <u>11/16/57</u> to <u>2/3/58</u> and last saw him alive on <u>2/3/58</u> <u>6:55 PM</u> m of the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Jack T. Steele M.D.</u> (Degree or title)		22b. ADDRESS <u>401 N. Florissant Ferguson 21, Mo.</u>		22c. DATE SIGNED <u>2/4/58</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>Feb. 7 1958</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Resurrection Cemetery</u>	
		23d. LOCATION (City, town, or county) <u>St. Louis County, Missouri</u>			
24. FUNERAL DIRECTOR <u>Math Hermann &amp; Son, Inc., 2161 E. Fair</u>		25. DATE RECD. BY LOCAL REG. <u>FEB 4 '58</u>		26. REGISTRAR'S SIGNATURE <u>Carl Smith MO</u> <u>msb</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATE

Ref. a. 1, 16, 18

All diseases in Part I must be causally related.

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 *Walter S. Burnley* .....

Licensed Embalmer No. *4202* .....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.