

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-042865  
STATE FILE NUMBER

FILED DEC 1 1958 Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3089

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Mt. Pleasant</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Mt. Pleasant</b> <b>4000</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Lackland Ave.</b>		Length of stay in lb <b>47 years</b>	d. STREET ADDRESS (If outside, give location) <b>Lackland, Ave.</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Henry Frederick Niedringhaus</b>			4. DATE OF DEATH Month Day Year <b>Nov. 25, 1958</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 13, 1879</b>	9. AGE (In years) ( <sup>100</sup> birthday) <b>79</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	11. BIRTHPLACE (City and state or country) <b>Mt. Pleasant, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>Carl Niedringhaus</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Olivia A. Niedringhaus</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>493-42-9337</b>	17. INFORMANT Address <b>Olivia A. Niedringhaus, Lackland, Ave.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>metastatic CARCINOMA</b>					INTERVAL BETWEEN ONSET AND DEATH <b>2 mos.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Sq. Cell Carc Lt Floor of Mouth 1 year.</b>					
DUE TO (c) <b>143X</b>					
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 <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. I attended the deceased from <b>10-28-58</b> to <b>11-18-58</b> and last saw her alive on <b>11-18-58</b> Death occurred at <b>6:15 a.m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Deceased or title) <b>Robert R. Dombke M.D.</b>			22b. ADDRESS <b>1105 Central Clayton Mo</b>		22c. DATE SIGNED <b>11-25-58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>11-28-1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Paul's Ev. Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Olivette, Missouri</b>
24. FUNERAL DIRECTOR <b>Baumann Bros. Inc. Overland, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>11-25-58</b>	26. REGISTRAR'S SIGNATURE <b>Robert R. Dombke M.D.</b>		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *David C. Gibson* .....

Licensed Embalmer No. *3454* .....  
P. O. Address *Overland, 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.