

**FEDERAL BUREAU OF INVESTIGATION - U.S. DEPARTMENT OF JUSTICE**

**JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

FILED VS NOV 6 1959

59-037910

210004

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

INDEXED

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, give TOWNSHIP only) OR TOWN <b>ST LOUIS, MISSOURI</b>		c. CITY OR TOWN <b>St. Louis</b>	
Length of stay in 1b		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>ST LOUIS CITY HOSP # 1</b>		d. STREET ADDRESS (If outside, give location) <b>2830 North Jefferson Ave.,</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>Jacob</b> Middle <b>M</b> Last <b>Neiner</b>	4. DATE OF DEATH Month <b>October</b> Day <b>28th</b> Year <b>1959</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>2/7/1884</b>	9. AGE (last birthday) <b>75</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Policeman</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Police Department</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Michael Neiner</b>	13b. MOTHER'S MAIDEN NAME <b>Mary Wild</b>	14. NAME OF HUSBAND OR WIFE <b>Unavailable</b>
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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>Nil.</b>	17. INFORMANT <b>John Neiner, 3611a Blair, Ave.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	<b>Pneumonia</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	<b>Passive Congestion</b>	
DUE TO (b)		
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Prostate Carcinoma</b>	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)
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20c. TIME OF INJURY Hour _____ 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
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21. I attended the deceased from <b>Sept. 25th, 1959</b> to <b>Oct. 28th, 1959</b> and last saw her/him alive on <b>Oct. 28th, 1959</b> Death occurred at <b>4:58 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <b>Paul J. Stein, M.D.</b>	22b. ADDRESS <b>1515 Lafayette Ave.</b>	22c. DATE SIGNED <b>10-28-59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>11-2-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Florissant, Mo.</b>
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24. FUNERAL DIRECTOR <b>Buchholz Mortuary, 5967 W. Florissant, Ave.</b>	ADDRESS	25. DATE REG. BY LOCAL REG. <b>OCT 31 1959</b>	26. REGISTRAR'S SIGNATURE <b>Paul Smith, M.D.</b>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

77

**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

*Lawrence O. Gerling*

Licensed Embalmer No. 4979

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.