

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-017195

FILED VS APR 29 1960

2 3555

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 23 Hrs.	c. CITY OR TOWN Sherman
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Deaconess Hosp.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) St. Paul Rd.
		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last Anna K. Niere			4. DATE OF DEATH Month Day Year March 27 1960		
5. SEX female	6. COLOR OR RACE white	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9-2-91	9. AGE (last birthday) 68	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (City and state or country) St. Louis Co., Mo	12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Martin Sontag		13b. MOTHER'S MAIDEN NAME Charlotte		14. NAME OF HUSBAND OR WIFE Arthur F. Niere	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. no	17. INFORMANT Address Arthur Niere Rt 2, Ellisville Mo		

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>CARDIAL FAILURE</u>			INTERVAL BETWEEN ONSET AND DEATH 24 HRS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>HYPERTENSIVE ARTEROSCLEROTIC</u>		UNKNOWN
	DUE TO (c) <u>HEART DISEASE 443x</u>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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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. I attended the deceased from SEPT 6, 1957 to MAR. 26 1960 and last saw her alive on MAR. 26, 1960
Death occurred at 7 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>James E. Meyer, M.D.</u>		22b. ADDRESS <u>BALLWIN, Mo.</u>		22c. DATE SIGNED <u>MAR. 28 '60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>3-23-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. John Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Ellisville, Mo.</u>	
24. FUNERAL DIRECTOR <u>Schrader Funeral Home Ballwin, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>MAR 29 1960</u>	26. REGISTRAR'S SIGNATURE <u>Walter Smith, M.D.</u>	

M. J. B.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Richard Papp

Licensed Embalmer No.

4584

P. O. Address

Baltimore

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.