

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED MAY 13 1946

State File No. 14597
Registrar's No. 41

Registration District No. _____ Primary Registration District No. 3020

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

1. PLACE OF DEATH:
(a) County Franklin
(b) City or town Washington Mo.
(c) Name of hospital or institution: none
(d) Length of stay: In hospital or institution none
In this community 38 yrs -

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Franklin
(c) City or town 812 W. 7th St - 26
(d) Street No. Washington Mo.
(e) Citizen of foreign country? no

3. (a) PRINT FULL NAME JOHN PETER NEIER
3. (b) If veteran, name war none
3. (c) Social Security No. none

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 4 day 15
year 1944 hour 1:30 minute P M.
21. I hereby certify that I attended the deceased from December 1943 to April 1944
that I last saw him alive on April 15 and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Auna Haberberg
6. (c) Age of husband or wife if alive 57 years
7. Birth date of deceased August 31 - 1873

Immediate cause of death myocardial collapse
Due to Pulmonary congestion
Due to Thrombosis of cerebral vessels from fall 4 years ago
Other conditions (Include pregnancy within 3 months of death) _____

8. AGE: Years Months Days If less than one day
70 7 14 hr. _____ min.

Major findings: Of operations none
Of autopsy none
PHYSICIAN 9322
Underline the cause to which death should be charged statistically.

9. Birthplace Neier Mo-D
10. Usual occupation Factory Worker
11. Industry or business Corn Cab Piper
12. Name Peter Neier
13. Birthplace Switzerland
14. Maiden name Auna Gustaf Neier
15. Birthplace Neier Mo-D

16. (a) Informant Mrs John P. Neier
(b) Address Washington Mo
17. (a) Burial (b) Date thereof Apr-19-1944
(c) Place: burial or cremation Washington Mo
18. (a) Signature of funeral director Alto
(b) Address Washington Mo
19. (a) 4/17/44 (b) Shelley Ruthen Brook

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
While at work? _____ (Specify type of place)
(e) Means of injury _____
23. Signature R. E. White (M. D. or other) D.O.
Address Washington Mo Date signed 4/17/44

RECEIVED
District Health Officer No. 9,
District File Number _____
Date Filed 5-12-44

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 _____

J.H. Otto

_____, Registered Apprentice No. _____

working under my personal supervision.

Signed *J.H. Otto*

Licensed Embalmer No. 2464

P. O. Address Washington 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 this body is not embalmed, fact should be so stated above.