S. No. 2
1—1/47
5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED NOV 25 1947

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 40539

Registration District No. 577 Primary Registration District No. 6076 Registrar's No. 2406

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

1. PLACE OF DEATH:
(a) County St Louis
(b) City or town Manchester Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Manchester Nursing Home 4
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 15 Mons. (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County St Louis 96
(c) City or town St. Louis 0
(If outside city or town limits, write "RURAL")
(d) Street No. Manchester Nursing Home 0
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Frederick. Neuer
3. (b) If veteran, name war no
3. (c) Social Security No. no

4. Sex Male 0
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Gertrude Neuer 0
6. (c) Age of husband or wife if alive 67 years
7. Birth date of deceased 10 (Month) 31 (Day) 1856 (Year)

8. AGE: Years 91 Months 0 Days 18 If less than one day hr. min.

9. Birthplace St. Louis (City, town, or county) Mo. 0 (State or foreign country)
10. Usual occupation nil
11. Industry or business
FATHER
12. Name Unknown 9
13. Birthplace Unknown (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Unknown 9
15. Birthplace Unknown (City, town, or county) (State or foreign country)
16. (a) Informant Mrs Gertrude Neuer
(b) Address Manchester Nursing Home
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-22-47 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery
18. (a) Signature of funeral director Goodhart & Goodhart
(b) Address 2228 St. Louis Ave
19. (a) 11-21-47 (Date received local registrar) (b) Cecil A. Sharp (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 19
year 1947 hour 11 minute 45 a.M.

21. I hereby certify that I attended the deceased from July 22, 1947, to Nov. 19, 1947, that I last saw him alive on Nov. 17, 1947, and that death occurred on the date and hour stated above.

Immediate cause of death Caronary occlusion
Due to Arteriosclerosis Senility
Due to 940
Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

Duration

PHYSICIAN
Underline the cause of which death should be charged statistically.

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? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place) 0
While at work? (e) Means of injury

23. Signature Henry F. Scott (M. D. or other) M.D.
Address Ballwin Mo Date signed Nov. 19-47

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

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.....

..... Registered Apprentice No.....

working under my personal supervision.

Signed.....Henry M. Brammer

Licensed Embalmer No.....4200

P. O. Address.....St Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed. fact should be so stated above.

S. No. 2B
5M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Dec

Registration District No. 317 Primary Registration District No. 6076 Registrar's No. 2406

1. PLACE OF DEATH:

(a) County St Louis

(b) City or town Manchester
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Frederick Neuer

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Oct (Month) 31 (Day) 18 (Year)

8. AGE: Years 91 Months 0 Days 8 If less than one day hr. min.

9. Birthplace (City, town, or county) Mo (State or foreign country)

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) Cecila G Sharp M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Day 9
year 1942 hour minute M.

21. I hereby certify that I attended the deceased from
, 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

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? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

40539

RECEIVED
DEC 20 '94
ST. LOUIS COUNTY
HEALTH DEPT.
DANVILLE, IL