

No. 2  
5-43  
5-17-39  
X32671

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **43365**  
Registrar's No. **11702**

FILED JAN 9 1948

1003

Registration District No. **318** Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County **St. Louis**

(b) City or town **St. Louis**  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
**3335a Itaska St.**  
(If not in hospital or institution, write street number or location)

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

In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT **Anna Niehaus**  
FULL NAME

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex **Female** / 5. Color or race **White**

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

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive **9**, **1874** years  
(Month) (Day) (Year)

7. Birth date of deceased **January 9, 1874**  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
<b>73</b>	<b>11</b>	<b>13</b>		hr. min.

9. Birthplace **St. Louis Missouri**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Housework**

11. Industry or business \_\_\_\_\_

12. Name **Lambert Niehaus**

13. Birthplace **Germany**  
(State or foreign country)

14. Maiden name **Maria Schonigman**

15. Birthplace **Germany**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Mary Hughes**

(b) Address **3335a Itaska St.**

17. (a) **Burial** (b) Date thereof **12/24/47**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Peter & Paul Cemetery**

18. (a) Signature of funeral director **John H. Gebken Sons Und. Co.**

(b) Address **2630 Gravois Ave.**

19. (a) **DEC 23 1947** **J. F. Budnich**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis**

(c) City or town **St. Louis**  
(If outside city or town limits, write "RURAL")

(d) Street No. **3335a Itaska St.**  
(If rural, give location)

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

If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **December** day **22**,  
year **1947** hour **7, 55** minute **A** M.

21. I hereby certify that I attended the deceased from **December 18, 1947** to **Dec 22nd**, 1947  
that I last saw her alive on **Dec 22nd**, 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death **Asphyxiation cerebral hemorrhage**  
Due to **Bronchial pneumonia**

Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
(c) Means of injury \_\_\_\_\_

23. Signature **J. F. Budnich** (M. D. or other) \_\_\_\_\_  
Address **227 85th St** Date signed **12-25-47**

Duration **12h**  
**3 days**

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

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

---

**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 Robert F. Gebken

Licensed Embalmer No. 4140

P. O. Address 2630 Gravois Ave.

**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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Jan 1170-2  
Registrar's No. 1170-2

Registration District No. 318 Primary Registration District No. 1003

1. PLACE OF DEATH:  
(a) County \_\_\_\_\_  
(b) City or town ST. LOUIS  
(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

3. (a) PRINT FULL NAME Anna Nichols  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced \_\_\_\_\_  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_  
7. Birth date of deceased Jan 9 1899  
(Month) (Day) (Year)

8. AGE: Years 73 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
12. Name \_\_\_\_\_  
13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_  
(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation \_\_\_\_\_

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

19. (a) 12-23-1947 (b) J. F. Brodeur  
(Date received local registrar) (Registrar's Signature)

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 \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month \_\_\_\_\_ Day \_\_\_\_\_ Year 1947 Hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

PHYSICIAN  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
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? \_\_\_\_\_  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

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

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

SUPPLEMENTARY

43305