MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County Clark

Township Vernon

or Village ~~Alexandria~~

or City _____ (NO. _____ St.; _____ Ward)

Registration District No. 189 File No. 8503

Primary Registration District No. 5263 Registered No. _____

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Lewis F Ziegler

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): single

DATE OF BIRTH: July (Month) 1 (Day), 1862 (Year)

AGE: 50 yrs. 8 mos. 26 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Store Keeper

(b) General nature of industry, business, or establishment in which employed (or employer): 4-36

BIRTHPLACE (City or town, State or foreign country): Keokuk Ia

PARENTS

NAME OF FATHER: Lewis Ziegler

BIRTHPLACE OF FATHER (City or town, State or foreign country): dont Know

MAIDEN NAME OF MOTHER: Katherine Schmidt

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Germany

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs H Dedman

(ADDRESS) Alexandria Mo

Filed Mch 28, 1913. F. A. S. Rebo REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Mch (Month) 27 (Day), 1913 (Year)

I HEREBY CERTIFY, that I attended deceased from Mch 27, 1913, to Mch 27, 1913, that I last saw him alive on Mch 27, 1913, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Apoplexy.

X2.A

(Duration) ___ yrs. ___ mos. 1 ds.

Contributory (SECONDARY) ✓

(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) Dr. F. A. S. Rebo M. D.

Mch 28, 1913 (Address) Alexandria

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury: and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL: Warsaw Ill

DATE OF BURIAL: Mch 1, 1913

UNDERTAKER: Mr. Huston

ADDRESS: Warsaw Ill

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County.....

Township.....
or
Village.....
or
City.....(NO.....,.....St.;.....Ward)

Registration District No..... File No.....

Primary Registration District No..... Registered No.....

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME.....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

.....(Month).....(Day), *1*.....(Year)

AGE

.....yrs.....mos.....ds.

If LESS than 1 day,.....hrs. or.....min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant).....

(ADDRESS).....

Filed .....,191....., ...
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

.....(Month).....(Day), *191*.....(Year)

I HEREBY CERTIFY, that I attended deceased from .....,191....., to.....,191.....,
that I last saw h.....alive on.....,191.....,
and that death occurred, on the date stated above, at.....m.
The CAUSE OF DEATH* was as follows:

.....

.....

.....(Duration).....yrs.....mos.....ds.

Contributory.....
(SECONDARY)
.....(Duration).....yrs.....mos.....ds.

(Signed).....M. D.

.....,191..... (Address).....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted if not at place of death? .....

Former or usual residence.....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL .....,191.....
UNDERTAKER	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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