G. Kistler

REC'D JUN 14 1939

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

19608
Do not use this space.

1. PLACE OF DEATH
(a) County (St. Charles)
(b) Township or
(c) City St. Charles
Registration District No. 757
Primary Registration District No. 3036 Registered No. 76
(d) Street No. St. Joseph Hospital St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME John Henry Zerr
(a) Residence, No. 1407 N. Fifth St. St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Anna Rieper
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug. 6, 1882
7. AGE: Years 56 Months 9 Days 18 If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Carpenter Trade
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation 0

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Peters, Mo. 0

FATHER
13. NAME John Zerr 0
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Peters, Mo.

MOTHER
15. MAIDEN NAME Gertrude Ernst
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Peters, Mo.

17. INFORMANT Mrs. Anna Zerr
(ADDRESS) 1407 N. Fifth, St. Charles, Mo.
18. BURIAL, CREMATION, OR REMOVAL St. Charles, Mo.
PLACE Barromeo Cemetery DATE May 27, 1939
19. FUNERAL DIRECTOR (NAME) W. C. Ballmeyer & Sons Co.
(ADDRESS) St. Charles, Mo.
20. FILED 5/27, 1939 Clarence R. Wessler
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 24, 1939
22. I HEREBY CERTIFY, That I attended deceased from 5/28, 1938, to 5/24, 1939
I last saw him alive on 5/24, 1939. Death is said to have occurred on the date stated above, at 2:45 Am.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Apoplexy	5/28/38
Fractured of right hip	5/17/39
	0

Other contributory causes of importance:

Name of operation ..... Date of ....
What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ....., 19....
Where did injury occur? .....
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury .....
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify .....
(Signed) G. Kistler, M. D.
(Address) St. Charles, Mo.

(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.....

Licensed Embalmer No.....

P. O. Address.....

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

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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

19608 X
Do not use this space.

1. PLACE OF DEATH
(a) County St Charles — Registration District No. 757
(b) Township — Primary Registration District No. 3036 — Registered No.
(c) City St Charles — (d) Street No. ..... St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. — (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME John Henry Zeer
(a) Residence, No. ..... St. ☐ .....
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
M	W	Wid

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	56	9	18	

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER
13. NAME
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
PLACE ..... DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED ..... 19 .....
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5 - 24, 1939

22. I HEREBY CERTIFY, That I attended deceased from ..... 19 ..... to ..... 19 .....
I last saw h..... alive on ..... 19 ..... Death is said to have occurred on the date stated above, at ..... m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
apoplexy	
Fracture Rt Hip	
186 a	

Other contributory causes of importance:

Name of operation — Date of .....
What test confirmed diagnosis? — Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? accident Date of injury 5/17, 1939
Where did injury occur? at own home
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury fell on right hip
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) G. E. Kiesler, M. D.
(Address) St Charles Mo

SUPPLEMENTARY

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.
REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.