

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

24086  
Do not use this space.

1. PLACE OF DEATH

(a) County ..... Registration District No. **791**  
(b) Township ..... Primary Registration District No. **1003**  
(c) City **St Louis** (d) Street No. **5101 Cates** Registered No. **6359**  
(If death occurred in Hospital or Institution, write its name instead of street and number) St. \_\_\_\_\_  
(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

(a) Residence, No. **Mrs Lennette Zeigler 246** St. **12**  
(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 **Female** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Widow**  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Oliver A Zeigler July 15th/1939**  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Sept 27, 1852**  
7. AGE YEARS **86** MONTHS **9** DAYS **20** If LESS than 1 day, ..... hrs. or ..... min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **At Home**  
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)

**St Cathina**

FATHER

13. NAME **Marcus A Baker**  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Penna**

MOTHER

15. MAIDEN NAME **Laura Tucker**  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Maryland**

17. INFORMANT (ADDRESS)

**Miss M E Baker 5101 Cates Ave.**

18. BURIAL, CREMATION, OR REMOVAL PLACE

**Valhalla Crematory July 20, 1939**

19. FUNERAL DIRECTOR (ADDRESS)

**Bowland Mortuary Soc 4365 Washington**

20. FILE

**HL 19 1939 J F Rudolph Registrar.**

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **July 17th 1939**  
22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to **July 17th/39**, 19\_\_\_\_  
I last saw her alive on **July 17th, 1939**. Death is said to have occurred on the date stated above, at **8:30 P.M.**  
The principal cause of death and related causes of importance were as follows:

**Myocarditis** Date of onset **1/15/39**  
**acute exacerbation** **July 15/39**  
Other contributory causes of importance:  
**MO**

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? **cardiac** Was there an autopsy? **no**

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? **no** 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?  
If so, specify **no**  
(Signed) **M Geo Gorman**, M. D.  
(Address) **5249 Raymond Ave St. Louis** Mo

**STATEMENT BY LICENSED EMBALMER**

I, \_\_\_\_\_, Licensed Embalmer No. \_\_\_\_\_  
hereby certify that the body recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
\_\_\_\_\_ L. E. \_\_\_\_\_  
No. \_\_\_\_\_ or by \_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_  
working under my personal supervision.

Signed *Howard B. Rowland*

Licensed Embalmer No. *3114*

**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.)**