

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**

20721
Do not use this space.

1. PLACE OF DEATH
 (a) County Jackson Registration District No. 399
 (b) Township Jansas Primary Registration District No. 1002 Registered No. 2338
 (c) City Coopers City (d) Street No. Vineyard Park Hosp. 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. 1 How long in U. S., if of foreign birth? yrs. mos. ds. _____

2. PRINT FULL NAME Hannie Ziegler
 (a) Residence, No. Vineyard Park Hosp St. St. Joseph, Mo. R.R. #5
 (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) Married

6A. IF MARRIED, WIDOWED, OR DIVORCED
 HUSBAND OF (OR) WIFE OF Joe Ziegler

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar 18, 1875

7. AGE YEARS 65 MONTHS 2 DAYS 19 If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
 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) Mo

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

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

17. INFORMANT (ADDRESS) Mollie Streeter
Excelsior, Mo.

18. BURIAL, CREMATION, OR REMOVAL
 PLACE Excelsior Springs DATE 6-7, 1946

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Claude Michael
Excelsior Springs, Mo.

20. FILED JUNE 7, 1940 M-M Crowe
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 7, 1940

22. I HEREBY CERTIFY, that I attended deceased from June 6, 1940 to June 7, 1940
 Last saw him/her alive on June 6, 1940 Death is said to have occurred on the date stated above, at 4:20 a.m.
 The principal cause of death and related causes of importance were as follows:
Chronic Myocarditis
Chronic Hypertension
Nephritis 131
 Date of onset 6-9-40
6-7-40

Other contributory causes of importance: _____

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? no

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) John Helder, M. D.
 (Address) 25th & Locust

STATE OF TEXAS
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS

good



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,

Not Embalmed

or by

Registered Apprentice No., working under my personal supervision.

Signed *Charles P. Michael*

Licensed Embalmer No. *2751*

P. O. Address *Exclusion Springs*

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, above space should be left blank.