

S. No. 2
1-8-43
5-17-39
1 X37823

FILED AUG 28 1944
Registration District No. **3068**

Primary Registration District No. **3068**

Registrar's No. **1756**

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

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Richmond Heights
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Mary's Hospital
(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.....

3. (a) PRINT FULL NAME Kenneth John Ziegerer

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male 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..... years

7. Birth date of deceased July 19, 1944
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
		<u>29</u>	hr. min.

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

10. Usual occupation Infant

11. Industry or business.....

MOTHER FATHER

12. Name Henry Ziegerer

13. Birthplace Moselle Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Roberta Herdon

15. Birthplace Unknown Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Henry Ziegerer

(b) Address St. Clair, Mo.

17. (a) Burial (b) Date thereof 8-21-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Moselle, Missouri

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) **AUG 22 1944** (b) C. J. McLeven, M.D.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Franklin

(c) City or town St. Clair
(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 August day 18
year 1944 hour 4:55 minute A. M.

21. I hereby certify that I attended the deceased from July 19 to Aug 18
that I last saw him alive on Aug 17
and that death occurred on the date and hour stated above.

Immediate cause of death:
Septic meningitis
non epidemic

Due to.....

Due to.....

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations SIA

Of autopsy As above

Duration

PHYSICIAN

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 J. W. Wistar White (M. D. or other)
Address 4500 P. Drive Date signed 8/21/44

AUG 29 1944

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.....

John Ogroski

Licensed Embalmer No.....

3398

P. O. Address.....

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.