

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

FILED MAR 19 1945

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

9215

State File No.

Registrar's No. 205

Registration District No. 42

Primary Registration District No. 1000

1. PLACE OF DEATH

(a) County St. Joseph Mo
(b) City or town St. Joseph Mo
(c) Name of hospital or institution State Hospital
(d) Length of stay: In hospital or institution 2 yrs 1 mo 15 days
In this community yes years, months or days

3. (a) PRINT FULL NAME Dollie Ziegler

3. (b) If veteran, name war nil 3. (c) Social Security No. nil

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Ors Ziegler 6. (c) Age of husband or wife if alive not given years
7. Birth date of deceased 19-1882 (Month) (Day) (Year)

8. AGE: Years 62 Months 3 Days 2 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business at home

12. Name J. A. Missiler
13. Birthplace Uniontown Pa (City, town, or county) (State or foreign country)
14. Maiden name NOT KNOWN
15. Birthplace Pa (City, town, or county) (State or foreign country)

16. (a) Informant Ors Ziegler
(b) Address St. Joseph Mo

17. (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof 2-21-1945 (Month) (Day) (Year)

(c) Place: burial or cremation CEARDO - MISSOURI

18. (a) Signature of funeral director Walter Meierhoffer
(b) Address 302 Gary St. ST. JOSEPH, MO.

19. (a) 2/21/45 (Date received local registrar) (b) John J. Gable (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St. Joseph
(c) City or town St. Joseph Mo (If outside city or town limits, write "RURAL")
(d) Street No. 1 (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2/21 day 21 year 1945 hour 11 minute 0 M.

21. I hereby certify that I attended the deceased from Jan 1st 1945 to Feb 21 1945
that I last saw him alive on Feb 20 1945
and that death occurred on the date and hour stated above.

Immediate cause of death bronchial pneumonia Duration 3 days

Due to Do not know

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 107

Of autopsy

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 John J. Gable (M. D. or other)
Address State Hospital St. Joseph Mo Date signed 2/21/1945

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(Licensed Embalmer's Statement on Reverse Side)

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

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

Albert R. Harington

Licensed Embalmer No.

2258 Mo.

P. O. Address

St. Joseph, Mo.

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.