

S. No. 2
M-5-43
7-5-17-39
I X36671

FILED MAR 1 1946
318

1003

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County St. Louis, Missouri

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Louis City Hospital - Max C. Starkloff
(If not in hospital or institution, write street number or location) Memorial

(d) Length of stay: In hospital or institution 15 days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 6000

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. St. Ann's Home - 5301 Page
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME ALICE ZIEGLER

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

4. Female 5. Color or race white

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Charles 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased January 25th, 1863
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 14th
year 1946 hour 9:50 minute _____ PM _____ M.

21. I hereby certify that I attended the deceased from 1/29/46
_____ 19 _____ to 2/14/46 19 _____
that I last saw her alive on 2/14/46 19 _____
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>83</u>	<u>0</u>	<u>19</u>	hr. _____ min. _____

Immediate cause of death Broncho-pneumonia Duration

9. Birthplace England 4
(City, town, or county) (State or foreign country)

10. Usual occupation Nil

11. Industry or business _____

12. Name John Reading

13. Birthplace England 4
(City, town, or county) (State or foreign country)

14. Maiden name Eliza Beale

15. Birthplace England 4
(City, town, or county) (State or foreign country)

Due to Post operative debility after operation of amputation of leg for gangrene

Due to Due to diabetic arteriosclerosis

Other conditions Fractured nose
(Include pregnancy within 3 months of death)

Major findings Suppurative parotitis PHYSICIAN

Of operations Gangrene of thumb and rest of leg

Of autopsy _____ Underline the cause to which death should be charged statistically.

16. (a) Informant Sister Louise

(b) Address St. Ann's Home

17. (a) Burial (b) Date thereof 2-18-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cemetery

18. (a) Signature of funeral director Chas. F. Stuart

(b) Address 1225 Union Blvd.

19. (a) FEB 15 1946 (b) J. F. Breneck
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) fractured nose non-contributing

(b) Date of occurrence 1/29/46

(c) Where did injury occur? St. Louis Mo.
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
in hospital

While at work? no (Specify type of place) (e) Means of injury fell out of bed

23. Signature W. F. Hamilton 2/15/46 (other) _____
1515 Lafayette Date signed

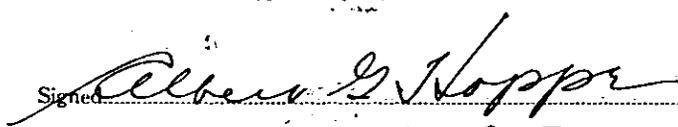
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....



Licensed Embalmer No. 2971.....

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.