

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **27219**

2005-0

FILED JUL 23 1953

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 547 Registrar's No. 1975

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Richmond Heights		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Lake, Chesterfield Mo. R. 1	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Marys Hospital		d. STREET ADDRESS (If rural, give location) Olive Street Road	
3. NAME OF DECEASED (Type or Print) a. (First) Wilhelmina b. (Middle) Louise c. (Last) Zierenberg			4. DATE OF DEATH (Month) (Day) (Year) 7-4-53
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH Mar. 19-1877
9. AGE (In years last birthday) 76		10. MONTHS 3	11. DAYS 15
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY At home	11. BIRTHPLACE (City and State or Foreign Country) St. Louis Co., Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Herman Schaeper	
13b. MOTHER'S MAIDEN NAME Agnes Kroening		14. NAME OF HUSBAND OR WIFE Ernst W. Zierenberg	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Herbert C. Zierenberg, Chesterfield, Mo.
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral apoplexy ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cardiovascular disease DUE TO (c) Hypertension II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 443X	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, shop, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>1950</u> , to <u>7/4</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>7/3</u> , 19 <u>53</u> , and that death occurred at _____ m., from the causes and on the date stated above.			
23a. SIGNATURE Cominella M.D.		23b. ADDRESS 1161 Fenwick	23c. DATE SIGNED 7/7/53
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 7-7-53	24c. NAME OF CEMETERY OR CREMATORY St. John, Bellefontaine	24d. LOCATION (City, town, or county) (State) Bellefontaine, Mo.
DATE REC'D BY LOCAL REG. 7-7-53	REGISTRAR'S SIGNATURE Herbert R. Donke M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Schrader Funeral Home, Ballwin Mo.	

SW (Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Hea. Scheeler

Licensed Embalmer No. 3066

P. O. Address Dalkevia, 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.