

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30216

State File No.

FILED AUG 26 1957

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **7077**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis	c. LENGTH OF STAY (In this place)	c. CITY OR TOWN St. Louis	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION 31 St. Louis State Hospital		e. STREET ADDRESS (If rural, give location) 2479 0354 Wisconsin Ave.	
3. NAME OF DECEASED (Type or Print) a. (First) Anna		b. (Middle)	c. (Last) Ziegler
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWER, DIVORCED (Specify) Single	4. DATE OF DEATH (Month) (Day) (Year) July 28, 1957
8. DATE OF BIRTH July 14, 1925	9. AGE (In years last birthday) 32	IF UNDER 1 YEAR Months	IF UNDER 1 MRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME William Ziegler	13b. MOTHER'S MAIDEN NAME Josephine Davidson	14. NAME OF HUSBAND OR WIFE	

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 William Ziegler	ADDRESS 3541 Wisconsin Ave.
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Abscess of brain or cyst of brain		INTERVAL BETWEEN ONSET AND DEATH
	2. ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, 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 June 12, 1957 to July 28, 1957, that I last saw the deceased alive on July 28, 1957, and that death occurred at 4:15p m., from the causes and on the date stated above.

23a. SIGNATURE <i>Alena Hyman</i> (Degree or title)	23b. ADDRESS 5100 Arsenal Street	23c. DATE SIGNED 7/29/57
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE July 30, 1957	24c. NAME OF CEMETERY OR CREMATORY St. Matthews Cem.	24d. LOCATION (City, town, or county) (State) St. Louis, Missouri
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DATE REC'D BY LOCAL REG. JUL 30 57	REGISTRAR'S SIGNATURE <i>J. Carl Smith M.D.</i>	25. FUNERAL DIRECTOR'S SIGNATURE Schumacher's	ADDRESS 3013 Meramec St.
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(Licensed Embalmer's Statement on Reverse Side)

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

0.300
0.48

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.....
Signature of Student Embalmer

Signed.....

Jack (Lynch)

Licensed Embalmer No. 47

P. O. Address *St. Louis*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.