

S. No. 2
1-1-4-41
5-17-39
I X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
APR 15 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

9496
State File No. _____
Registrar's No. 905

Registration District No. 279

Primary Registration District No. 1002

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(c) Name of hospital or institution K.C. General Hospital
(d) Length of stay: In hospital or institution 17 days
In this community 58 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri
(b) County Jackson
(c) City or town Kansas City
(d) Street No. North Hotel, 2027 Main
(e) Citizen of foreign country? No

3. (a) PRINT FULL NAME Charles Zeigler
3. (b) If veteran. name war
3. (c) Social Security No.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Feb. day 26th
year 1941 hour 7 minute 50 P. M.
21. I hereby certify that I attended the deceased from 2-9-41 to 2-26-41
that I last saw him alive on 2-26-41
and that death occurred on the date and hour stated above.

4. Sex MO
5. Color or race W.
6. (a) Single, widowed, married, divorced W
6. (c) Age of husband or wife if alive years 15
7. Birth date of deceased April 15 1860

Immediate cause of death
Cardiac decompensation

8. AGE: Years 80 Months 10 Days 15
If less than one day hr. min.

Due to _____
Due to _____
Other conditions _____
Major findings: Of operations _____
Of autopsy _____

9. Birthplace 0 MO
(City, town, or county) (State or foreign country)

10. Usual occupation nurse
11. Industry or business _____
12. Name John Zeigler
13. Birthplace Kansas
14. Maiden name unknown
15. Birthplace unknown

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?

16. (a) Informant Record Clerk
(b) Address N.E. Gen Hospt
17. (a) Burial (b) Date thereof 3-3-41
(c) Place: burial or cremation Memorial Park
18. (a) Signature of funeral director Wm A. Schmeyer
(b) Address N.E. Gen Hospt
19. (a) 3/3/41 (b) M. M. Brown

23. Signature Wm R. Thron (M. D. or other)
Address Med. Dir. K.C. Gen. Hospital Date signed _____

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

48
38

MOTHER FATHER

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

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.....

Wm. A. Lohmeyer

Licensed Embalmer No.....

3084

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.