

No. 2  
1-5-43  
5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **8129**  
**2015**  
Registrar's No.

Registration District No. **318** Primary Registration District No. **1003**

1. PLACE OF DEATH: **318**  
(a) County **St. Louis**  
(b) City or town **St. Louis**  
(c) Name of hospital or institution: **Park Lane Hospital**  
(d) Length of stay: In hospital or institution (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Mo.** (b) County **000**  
(c) City or town **St. Louis** (If outside city or town limits, write "RURAL") **617**  
(d) Street No. **4832 Leduc St.** (If rural, give location) **9**  
(e) Citizen of foreign country? (Yes or No) **0**  
If yes, name country

3. (a) PRINT FULL NAME **Adolph G. Zogg**  
(b) If veteran, name war (c) Social Security No.

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**  
6. (b) Name of husband or wife **Nellie A. Zogg** 6. (c) Age of husband or wife if alive **73** years  
7. Birth date of deceased **Nov. 22nd. 1867** (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**78** **3** **5** hr. min.

9. Birthplace **Kimmswick Mo.** (City, town, or county) (State or foreign country)

10. Usual occupation **Upholsterer**

11. Industry or business **Retired**

MOTHER FATHER

12. Name **Florian Zogg** **5**

13. Birthplace **Switzerland** (City, town, or county) (State or foreign country)

14. Maiden name **Unknown**

15. Birthplace **Switzerland** (City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Nellie A. Zogg**

(b) Address **4832 Leduc St.**

17. (a) **Cremation** (b) Date thereof **3-1-46** (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Valhalla Crematory**

18. (a) Signature of funeral director **Drehmann-Harral**

(b) Address **1905 Union Blvd.**

19. (a) **FEB 28 1946** **J. F. Bredebeck** (Date received by Registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb.** day **27th** year **1946** hour **4** minute **20** P.M.  
21. I hereby certify that I attended the deceased from **Nov. 1st** to **Feb 22nd** 19 **46** that I last saw him alive on **Feb 22nd** 19 **46** and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic Myocarditis** Duration **1 1/2 years**

Due to  
Due to  
Other conditions (Include pregnancy within 3 months of death) **9/3**

Major findings: Of operations  
Of autopsy  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

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) (c) Means of injury  
3. Signature **Spencer B. Kane** (M. D. or other) **MM-10**  
Address **1706 Walnut** Date signed **2/28/46**

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

706  
12-2

**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 Warren A. Carver  
Licensed Embalmer No. 3534

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.**