

FILED MAR 21 1946  
Registration District No. ( )

Primary Registration District No. ( )

Registrar's No. ( )

1. PLACE OF DEATH  
(a) County Ray  
(b) City or town Craigsville Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community \_\_\_\_\_ (Specify whether)  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State L (b) County 89  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME LUTHER ZIESENISS  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month July day 16  
year 1946 hour 23 minute 50 P.M.

4. Sex Male 5. Color or race White  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years (Day) (Year)  
7. Birth date of deceased May 2 1869  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Nov. 1st 1945 to Feb. 16 1946  
that I last saw him alive on Feb. 16 1946  
and that death occurred on the date and hour stated above.

8. AGE: Years — Months Days If less than one day  
76 9 11 hr. min.

Immediate cause of death Lobar Pneumonia Duration 3 days  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

9. Birthplace Ray County Mo.  
(City, town, or county) (State or foreign country)  
10. Usual occupation Farmer

Other conditions Chronic Myocarditis  
(Include pregnancy within 3 months of death)

MOTHER { 12. Name Henny Ziesenis  
13. Birthplace Germany  
(City, town, or county) (State or foreign country)  
14. Maiden name Antonia  
15. Birthplace Germany  
(City, town, or county) (State or foreign country)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy 108

16. (a) Informant Mrs. Lida Stephenson  
(b) Address Craigsville Mo.  
17. (a) (Burial, cremation, or removal) \_\_\_\_\_ (b) Date thereof: 2-16-1946  
(Month) (Day) (Year)

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? \_\_\_\_\_

(c) Place: burial or cremation Craigsville Mo.  
18. (a) Signature of funeral director C. A. K. Smith  
(b) Address Craigsville Mo.  
19. (a) Feb 23/46 (b) Joan Mills  
(Date received local registrar) (Registrar's signature)

(Specify type of place) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_  
23. Signature O. C. Kilbourn (M. D. \_\_\_\_\_)  
Address Craigsville, Mo. Date signed 2-17-46

213 (Licensed Embalmer's Statement on Reverse Side)

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

MOTHER {

APR 1 1946

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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~~.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed..... *W. Reed* .....  
Licensed Embalmer No. *2194* .....  
P. O. Address..... *Cougill 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.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

## 1. PLACE OF DEATH:

- (a) County Ray County  
 (b) City or town Cowgill Mo Rural  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: \_\_\_\_\_

(If not in hospital or institution, write street number or location)

- (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days)3. (a) PRINT FULL NAME Luther Ziesenis

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

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased May 5 1906  
(Month) (Day) (Year)

8. AGE: Years 76 Months \_\_\_\_\_ Days \_\_\_\_\_ (If less than one day) \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business
- Farmer

12. Name
- Luther Ziesenis

13. Birthplace
- Germany
- (City, town, or county) \_\_\_\_\_ (State or foreign country)

14. Maiden name
- Wisk

15. Birthplace
- Germany
- (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant
- Mrs Ada Stephenson

- (b) Address
- Cowgill, Mo

17. (a)
- Rural
- (b) Date thereof
- 3/16/1946
- 
- (Burial, cremation, or removal) (Month) (Day) (Year)

- (c) Place: burial or cremation
- Cowgill Cem.

18. (a) Signature of funeral director
- Carl E. Reed

- (b) Address
- Cowgill, Mo.

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_
- 
- (Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

- (a) State MO. (b) County Ray  
 (c) City or town near Cowgill Rural  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. High Grove Dr  
 (If rural, give location)  
 (e) Citizen of foreign country? no (Yes or No)  
 If yes, name country \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_;

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;

and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

## 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)  
(e) Means of injury \_\_\_\_\_23. Signature O. C. Kilbourn (M. D. or other) \_\_\_\_\_Address Cowgill, Mo Da signed 2-7-46

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

MOTHER FATHER

SUPPLEMENTARY

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. 297

Primary Registration District No. 6021

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Ray

(b) City or town Cowgill Rural  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME Luther Ziesenis

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased May 5 1946  
(Month) (Day) (Year)

8. AGE: Years 76 Months \_\_\_\_\_ Days \_\_\_\_\_ (If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.)

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name Henry Ziesenis

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

14. Maiden name Emouch

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

16. (a) Informant Mrs. Ada Stephens

(b) Address Cowgill, Mo.

17. (a) (Burial, cremation, or removal) \_\_\_\_\_ (b) Date thereof 26-6-46  
(Month) (Day) (Year)

(c) Place: burial or cremation Cowgill, Mo.

18. (a) Signature of funeral director C. H. LaReed

(b) Address Cowgill, Mo.

19. (a) May 17-46 (b) Maluel Jackson  
(Date received by local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Ray

(c) City or town Cowgill Rural  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July 1946 year. \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

PHYSICIAN \_\_\_\_\_

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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)

(e) Means of injury \_\_\_\_\_

23. Signature O. C. Kilbourn (M. D. or other) \_\_\_\_\_  
Address Cowgill Date signed MO

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

SUPPLEMENTARY