N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1928

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

32930

1. PLACE OF DEATH

County Cape Girardeau — Registration District No. 125 — File No.

Township " " — Primary Registration District No. 3009 — Registered No. 1206

City " " (No. , St. Ward)

2. FULL NAME Alice T. Zimmer

(a) Residence. No. 146 S. Benton St., Ward. (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 12 - 1925

7. AGE: Years 2 — Months 11 — Days 20 — If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): ✓
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Cape Girardeau Mo

PARENTS

10. NAME OF FATHER: Robert B. Zimmer
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Cape Girardeau Mo.
12. MAIDEN NAME OF MOTHER: Mary Wulfers
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Cape Gir. Co.

14. INFORMANT: Robert B. Zimmer
(Address) Cape Girardeau Mo

15. FILED 10/3, 1928 W. Kaempfe REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10 - 2 1928

17. I HEREBY CERTIFY, That I attended deceased from 10 - 1, 1928, to 10 - 2, 1928 that I last saw her alive on 10 - 2, 1928, and that death occurred, on the date stated above, at 3½ a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

107A
Pneumonia 105B ✓

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Laryngitis Ac.

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? —
DID AN OPERATION PRECEDE DEATH? NO DATE OF
WAS THERE AN AUTOPSY? NO
WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) C. L. Smith, M. D
, 19 (Address) Cape Girardeau Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: St. Marys Cem. — DATE OF BURIAL: Oct. 3 1928

20. UNDERTAKER: Walther Und Co. — ADDRESS: Cape Gir. Mo

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
County Cape Gir — Registration District No. 125 File No.
Township " " Primary Registration District No. 3009 Registered No. 1206
City " " (No. St. Ward)

2. FULL NAME Alice J. Zimmer
(a) Residence. No. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
F	W	S

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY)

14. INFORMANT
(Address)

15. FILED 10/3, 1928 W. C. Kaufman REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10 - 2 1928

17. I HEREBY CERTIFY, That I attended deceased from , 19 to , 19 that I last saw h alive on , 19 , and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pneumonia (Broncho)
x 100 d
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Laryngitis
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) , M. D
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

N. B.—Every item of information should be [illegible] supplied. [illegible] should be stated EXACTLY. IF [illegible] should sta[illegible] CAUSE OF DEATH in plain terms, so that [illegible] be properly classified. Exact statement of OCCUPATION is very important
REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-32930