

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.

FEB 21 1934

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Do not use this space.

1. PLACE OF DEATH

County.....Buchanan

Registration District No. 85

Township.....

Primary Registration District No. 1001

City.....St. Joseph

(No. Missouri Methodist Hospital)

St. Ward)

File No. 4027

Registered No. 192

2. FULL NAME Robert Zimmerman

(a) Residence, No.

St.

Ward.

New Hampton Missouri

(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

Male

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)

January 27, 1914

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1
day, ... hrs.
or min.

20

0

19

OCCUPATION

8. Trade, profession, or particular
kind of work done, as spinner,
sawyer, bookkeeper, etc.

Farmer

9. Industry or business in which
work was done, as silk mill,
saw mill, bank, etc.10. Date deceased last worked at
this occupation (month and
year)11. Total time (years)
spent in this
occupation12. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)Harrison Co.
Missouri

FATHER

13. NAME Thomas Zimmerman

14. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)Harrison Co.
Mo.

MOTHER

15. MAIDEN NAME Edna Mock

16. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)Harrison Co.
Mo.17. INFORMANT Thomas Zimmerman
(ADDRESS) New Hampton Mo.

18. BURIAL, CREMATION, OR REMOVAL

PLACE New Hampton Mo. DATE Febr. 18 1934

19. UNDERTAKER
(ADDRESS)H. R. Schindler
1802 Union St. St. Joseph Mo.

20. FILED

2-16-1934

John R. Schindler
Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) February 16 1934

22. I HEREBY CERTIFY, That I attended deceased from
2/10/34, 19, to 2/16/34, 19.

I last saw him alive on 2/16/34, 19. Death is said

to have occurred on the date stated above, at 10 P. m.

The principal cause of death and related causes of importance were as follows:

Localized Peritonitis
Perforated Appendix
Date of onset 2/3/34

Other contributory causes of importance

Name of operation. Appendectomy Date of 2/10/34

What test confirmed diagnosis? Spectator Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) O. Walling, M. D.

(Address) St. Joseph Mo.

