

AUG 11 1936

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

Do not use this space.

28262

1. PLACE OF DEATH

County.....

Registration District No. 791

Township.....

Primary Registration District No. 1003

City St. Louis, Missouri

City Hospital No. 1

File No. 8058

Registered No.

St. Ward)

B. 6298
2. FULL NAMEGustav Zoellner
6706 Colorado(a) Residence, No.
(Usual place of abode)

St. / Ward.

(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) married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <i>EMMA</i>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 13, 1853		
7. AGE	YEARS	MONTHS
82	9	15
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.		laborer
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 occupation

12. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY) Germany13. NAME *W. Zoellner*14. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY) *Germany*

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY) *Germany*17. INFORMANT *Hosp. Info. M.H. Kent*
(ADDRESS) *City Hospital No. 1*18. BURIAL, CREMATION, OR REMOVAL
PLACE *St. Francis* DATE *8-1-36*19. UNDERTAKER *C. H. ...*
(ADDRESS) *7649 Broadway*20. FILED *7-30-36* *J. Brebeck*
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7/29/36, 19

22. I HEREBY CERTIFY, That I attended, deceased from
7/24/36 7/29/36, 19

I last saw him alive on 7/29/36

Death is said to have occurred on the date stated above, at 3.45 p.m.

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

Chronic myocarditis
Bronchopneumonia
U2C

Other contributory causes of importance:
Hypertrophy of prostate
C. acute infection

Name of operation..... Date of.....

What test confirmed diagnosis? *Autopsy* Was there an autopsy? *Yes*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?.....

If so, specify.....

(Signed) *Thos W. Loan*, M. D.(Address) *City Hospital No. 1*

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.

