

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

11750

Registration District No. 571 Primary Registration District No. 5769 State File No. _____ Registrar's No. _____

1. PLACE OF DEATH:
(a) County Moniteau
(b) City or town _____
(c) Name of hospital or institution: _____
(d) Length of stay: In hospital or institution _____
In this community _____

3. (a) PRINT FULL NAME Mary Lue Zimmerman, 565
3. (c) Social Security No. _____
4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced _____
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased March 6 5 1940
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days 7 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
12. Name George H Zimmerman
13. Birthplace Brazito, Mo
14. Maiden name Clara B Blythe
15. Birthplace Been County, Mo

16. (a) Informant's own signature George H Zimmerman
(b) Address Center town Mo

17. (a) Burial (b) Date thereof March 14 40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New Hope
Jack Bowlin

18. (a) Signature of funeral director _____
(b) Address California, Mo

19. (a) 3-16-40 (b) HR Popejoy 504
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Moniteau
(c) City or town Rural
(d) Street No. Walker St
(e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Mar 12 day year 1940 hour 8 minute _____ M.
21. I hereby certify that I attended the deceased from Mar 6 to Mar 12 1940
that I last saw her alive on Mar 11 1940
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Encephalitis
Due to _____
Rachitis
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? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____
23. Signature Walter G Leslie (M. D. or other) _____
Address Russellville Mo Date signed _____

Duration
6 days
PHYSICIAN
Underline the cause to which death should be charged statistically

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

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

Rev. 5-17-30 I 11951

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UN SIGNED

STATE OF OHIO

DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

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 _____

Licensed Embalmer No. _____

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, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 11760

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 371

Primary Registration District No. 5769

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Moniteau

(b) City or town Waller - Ins
(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 Mary Lou Zimmerman

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased (Month) _____ (Day) _____ (Year) _____

8. AGE: Years _____ Months _____ Days 7 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof (Month) (Day) (Year) _____

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____ (If outside city or town limits write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) If foreign born, how long in U. S. A. ? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Mar day 17 year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19 _____ 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 encephalitis Duration _____
Was not epidemic

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

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 injury) _____ (e) Means of injury _____

23. Signature Walter L. Leckie (M.D. or other) _____

Address Russellville Tenn

SUPPLEMENTAL

11760 (1940)