

WHILE FLAINLY--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 state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Registration District No. 475

Primary Registration District No. 5580

Registrar's No. 14-23

1. PLACE OF DEATH:

(a) County JEFFERSON  
 (b) City or town RURAL - MERAMEC  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
ST. JOSEPH'S HILL INFIRMARY  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 1 MONTH, 11 DAYS  
 (Specify whether \_\_\_\_\_)  
 In this community \_\_\_\_\_  
 years, months or days)

3. (a) PRINT FULL NAME WILLIAM ZIHLMAN 455

8. (b) If veteran, name war NIL 8. (c) Social Security No. NIL

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced DIVORCED

6. (b) Name of husband or wife MARTHALENA JORDAN 6. (c) Age of husband or wife if alive UNKNOWN years

7. Birth date of deceased 5 29 1869  
 (Month) (Day) (Year)

8. AGE: Years 71 Months 10 Days 7 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace FOUR CORNERS IOWA  
 (City, town, or county) (State or foreign country)

10. Usual occupation FARMER

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

MOTHER FATHER { 12. Name LUCAS ZIHLMAN I

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

14. Maiden name CHARLOTTE JORDAN

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

16. (a) Informant's own signature Brother Bonaventura

(b) Address St. Joseph's Hill Infirmary

17. (a) Removal (b) Date thereof 4 6 1940  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wichita Falls Texas

18. (a) Signature of funeral director J. B. Sumner

(b) Address House Spring Inn

19. (a) 5 April 1940 (b) James A. Townsend  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County OREGON  
 (c) City or town RURAL - (THAYER)  
 (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 April day 5  
 year 1940 hour one minute 30 A. M.

21. I hereby certify that I attended the deceased from Feb. 24, 1940, to Apr. 4, 1940  
 that I last saw him alive on Apr. 4, 1940  
 and that death occurred on the date and hour stated above.

Immediate cause of death Broncho-pneumonia  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

Other conditions Secondary Gangrene  
 (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?  
301 (Specify type of place) \_\_\_\_\_ Means of injury \_\_\_\_\_

23. Signature Jesse S. Sargent (M. D. or other) \_\_\_\_\_  
 Address Wichita Falls, Mo. Date signed 4-5-40

Duration \_\_\_\_\_  
 PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically

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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 by.....

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

Signed *John T. Bennett*

Licensed Embalmer No. *1470*

P. O. Address *House Spring Rd*

**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

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. 15241

Registration District No. 425

Primary Registration District No. 5580

Registrar's No. 1423

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

1. PLACE OF DEATH

(a) County Jefferson  
(b) City or town Harrison T.P.  
(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 \_\_\_\_\_  
In this community \_\_\_\_\_ (Specify whether years, months or days)

3. (a) PRINT FULL NAME Williams Zihlman

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, Div

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

7. Birth date of deceased May 29 1869  
(Month) (Day) (Year)

8. AGE: Years 70 Months 10 Days 6 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 \_\_\_\_\_  
(Burial, cremation, or removal) (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.

3. MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 5- 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 \_\_\_\_\_

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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

CSM

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