

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH  
1003

State File No.

16684

Registration District No. 791

Primary Registration District No.

Registrar's No. 4162

1. PLACE OF DEATH:

(a) County St. Louis  
 (b) City or town St. Louis  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: Josephine Hospital  
 (If not in hospital or institution, write street number of dwelling)  
 (d) Length of stay: In hospital or institution 5 Days  
 (Specify whether  
 In this community Life.  
 years, months or days)

8. (a) PRINT FULL NAME Theresa Zurline 645

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. 490-03-4784

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single

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

7. Birth date of deceased Feb. 7 1891  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
49 3 1 hr. min.

9. Birthplace St. Louis Mo. C  
 (City, town, or county) (State or foreign country)

10. Usual occupation St. Louis Cordage Co.

11. Industry or business Rope Factory. 6

12. Name Frank Zurline 6

13. Birthplace Germany 6

14. Maiden name Anna Stoltze (State or foreign country)

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

16. (a) Informant's own signature May Leffler

(b) Address 4411 Neosho St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof May 11/40  
 (Month) (Day) (Year)

(c) Place: burial or cremation S.S. Peter & Paul

18. (a) Signature of funeral director [Signature]

(b) Address 2906 Gravois Ave.

19. (a) MAY 9 1940 (Date received local registrar) (b) [Signature] (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
 (c) City or town St. Louis. Mo. 23  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 814 Geyer Ave.  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 8th  
 year 1940 hour 12 30 A. M. minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from 5-3  
 \_\_\_\_\_, 1940, to 5-8 \_\_\_\_\_, 1940  
 that I last saw her alive on 5-7 \_\_\_\_\_, 1940,  
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration \_\_\_\_\_

Due to hypertension

Due to \_\_\_\_\_

Other conditions (include pregnancy within 3 months of death) [Signature]

Major findings: Of operations [Signature]

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 place) (e) Means of injury \_\_\_\_\_

23. Signature L. F. Murphy (M. D. or other) \_\_\_\_\_

Address 1531-8-9 Date signed 5-8-40

U. S. 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.

**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. 3989

P. O. Address St. Louis, Mo

**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.**