

Registration District No. 614

Primary Registration District No. 5611

1. PLACE OF DEATH:

(a) County NEWTON
(b) City or town NEOSHO RURAL RT 5
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
GRANBY TOWNSHIP
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 20
(Specify whether
In this community
years, months or days)

3. (a) PRINT FULL NAME MINNIE ZELLNER

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

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

6. (b) Name of husband or wife LOUIS ZELLNER 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased APRIL 28 1868
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>72</u>	<u>6</u>	<u>22</u>	hr. _____ min.

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

10. Usual occupation _____

11. Industry or business HOOSEWIFE

MOTHER FATHER { 12. Name John Jaeger

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

14. Maiden name ANNA WAGEN REIDER

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

16. (a) Informant's own signature Emmit Frank

(b) Address NEOSHO Mo RT 5

17. (a) BURIAL (b) Date thereof Oct 22 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation FAMILY CEMETERY

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

(b) Address NEOSHO MISSOURI

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

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County NEWTON
(c) City or town NEOSHO RURAL RT 5
(If outside city or town limits, write "RURAL")
(d) Street No. GRANBY TOWNSHIP
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 20
year 1940 hour 10 minute P M.

21. I hereby certify that I attended the deceased from Jan
1939 to Oct 19 1940
that I last saw her alive on Oct 19 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Diabetes mellitus

Due to _____

Due to 5/9

Other conditions apoplexy
(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 Oct 20 1940

(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?

544
While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature C. E. Maness (M. D. or other)

Address Neosho Mo Date signed 10-21-40

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.

2025 RELEASE UNDER E.O. 14176

RECEIVED

District Health Officer No. 6.

District File Number ~~1140-2866~~ 2866

Date Filed NOV 14 1947

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.....

Lawrence Reed....., Registered Apprentice No. 202
working under my personal supervision.

Signed J. E. Brigham.....

Licensed Embalmer No. 2689

P. O. Address Neosho, 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **35933**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **619**

Primary Registration District No. **5811**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Newton**
(b) City or town **Granby 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 _____ (Specify whether

In this community _____ years, months or days)

3. (a) PRINT FULL NAME **Minnie Zellner**

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 **m**

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 **72** Months **6** Days **22** If less than one day hr. min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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) **10-22-40** (b) **R. E. Rolan** (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.

20. DATE OF DEATH: Month **Oct** day **20** 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 **O. E. Maness** (M. D. or other)

Address **Maness Mo** Date signed _____

SUPPLEMENTAL

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

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

