

Registration District No. **7911**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County _____
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of town or county)
(c) Name of hospital or institution: **3017 Keokuk St.**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether) **2**
In this community **Life**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County _____
(c) City or town **St. Louis** **24**
(If outside city or town limits, write "RURAL")
(d) Street No. **3017 Keokuk St.**
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

FILED DEC 11 1940

3. (a) PRINT FULL NAME **John H. Zorn**

3. (b) If veteran, name war: _____ 3. (c) Social Security No. **None**

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

6. (b) Name of husband or wife **Mollie Zorn** 6. (c) Age of husband or wife if alive: _____ years

7. Birth date of deceased **April 24, 1850**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	90	6	11	hr. _____ min.

9. Birthplace **St. Louis Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired 13 years**

11. Industry or business **Prior in Post Office 9**

12. Name **Unknown 9**

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

14. Maiden name **Unknown**

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

16. (a) Informant **Jacob Zorn**
(b) Address **3017 Keokuk St.**

17. (a) **Burial** (b) Date thereof **11/8/40**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **O.S.S. Peter & Paul**

18. (a) Signature of funeral director **Wacker-Welderle**
(b) Address **2331 S. Broadway**

19. (a) **NOV 8 1940** (b) **J.F. Prudech**
(Date received registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov.** day **5**
year **1940** hour **5** minute **20 P.M.**

21. I hereby certify that I attended the deceased from **July 30th 1935**
19____ to **Nov 5th 1940**
that I last saw him alive on **Nov 5th 1940**
and that death occurred on the date and hour stated above.

Immediate cause of death
Semite Debility
Arteriosclerosis
Due to _____
Due to _____

Duration
15 years
4 months
1 day

Other conditions (Include pregnancy within 3 months of death) **97**

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 place)
(c) Means of injury _____

23. Signature **Albert A. Berhardt** (M. D. or other)
Address **3438 S. Biddlewa** Date signed **11/6/40**

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

MOTHER FATHER

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, fact should be so stated above.