

No. 2  
1-4-41  
7-39  
X28390

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
AUG 28 1941

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 23624  
Registrar's No. 5966

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH:  
(a) County ST LOUIS  
(b) City or town ST LOUIS  
(c) Name of hospital or institution: ST LOUIS CHILDREN'S HOSPITAL  
(d) Length of stay: In hospital or institution 29 hrs  
In this community 22 months

3. (a) PRINT FULL NAME Zykan, Phyllis Jane  
3. (b) If veteran, name war No  
3. (c) Social Security No. No

4. Sex F 5. Color or race W  
6. (a) Single, widowed, married, divorced SD  
6. (b) Name of husband or wife \_\_\_\_\_  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Sept 28 1939

8. AGE: Years 1 Months 9 Days 21  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation NIL

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

MOTHER FATHER  
12. Name Frank Zykan  
13. Birthplace MO  
14. Maiden name Freda Graft  
15. Birthplace MO

16. (a) Informant Mary Bishop M.D.  
(b) Address St. Louis Children's Hospital

17. (a) Burial (b) Date thereof \_\_\_\_\_  
(c) Place: burial or cremation Lake Charles Park

18. (a) Signature of funeral director Baumann Bros Inc.  
(b) Address 2504 Woodson Rd. Overland Mo.

19. (a) JUL 22 1941 (b) J. J. Bredech  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State MISSOURI (b) County ST LOUIS Co.  
(c) City or town WELLSTON  
(d) Street No. 8269 BREMER AVE.  
(e) Citizen of foreign country? No

20. DATE OF DEATH: Month JULY day 20  
year 1941 hour 2 minute 05 A.M.  
21. I hereby certify that I attended the deceased from JULY 18 1941  
to JULY 20 1941  
that I last saw her alive on JULY 20 1941  
and that death occurred on the date and hour stated above.

MEDICAL CERTIFICATION  
Immediate cause of death: Terminal bronchopneumonia  
Due to Pneumococcus meningitidis  
Pharyngitis non diphtheritic  
Due to Chills Males  
Malnutrition  
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? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_  
23. Signature K. J. Blythe (M. D. or other) \_\_\_\_\_  
Address 599 So. Seegal Date signed 7-24-41

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

**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 *Oscar F. Mueller*.....

Licensed Embalmer No. *3039*.....

P. O. Address *Overland 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, fact should be so stated above.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 23624

Registrar's No. 5966

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

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 St. Louis Children's Hosp  
(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

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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July  
year 1941 day 23 minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_;  
\_\_\_\_\_ 19\_\_\_\_;  
that I last saw him/her alive on \_\_\_\_\_ 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Duration \_\_\_\_\_

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)  
(b) Did injury occur in or about home, on farm, in industrial place, in public place?  
\_\_\_\_\_ (Specify type of place)  
While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_  
23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

3. (a) PRINT FULL NAME Zykan, Phyllis Jane  
(b) If veteran, name war \_\_\_\_\_ (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 \_\_\_\_\_ years

7. Birth date of deceased \_\_\_\_\_  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_  
If less than one day \_\_\_\_\_ 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 7-23-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 9-16-41 (b) J. Bredich  
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

SUPPLEMENTARY

