

FILED FEB 1 1943

818

Registration District No.

1003

Registrar's No.

601

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

1. PLACE OF DEATH:

(a) County.....
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
2026 Knox
(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 Missouri (b) County.....
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 2026 Knox
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Adam J. Zumsteg

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

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

6. (b) Name of husband or wife Sophia Zumsteg 6. (c) Age of husband or wife if alive 64 years

7. Birth date of deceased August 1 1869
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
73 5 18 ..br. min.

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

10. Usual occupation Retired City Employee

11. Industry or business.....

12. Name Not known

13. Birthplace Not known Switzerland
(City, town, or county) (State or foreign country)

14. Maiden name Zumsteg

15. Birthplace Not known Switzerland
(City, town, or county) (State or foreign country)

16. (a) Informant Sophia Zumsteg

(b) Address 2026 Knox

17. (a) cremation (b) Date thereof 1/21/43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Missouri Crematory

18. (a) Signature of funeral director John Ziegenhain & Sons

(b) Address 7027 Graydon

19. (a) JAN 21 1943 (b) J. J. Bradeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 19
year 1943 hour 8:00 minute A. M.

21. I hereby certify that I attended the deceased from.....
..... 19..... to..... 19.....
that I last saw h..... alive on..... 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death.....

Cerebral Apoplexy

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) (f) Means of injury.....

23. Signature [Signature] (M. D. or other).....

Address [Signature] Date signed 1/21/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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..... *E. P. K. Russell*.....

Licensed Embalmer No. *3877*.....

P. O. Address *7027 Travis*.....

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.