

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6664

State File No. _____

Registrar's No. 131

FILED FEB 24 1944
Registration District No. 1000

Primary Registration District No. 1000

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
414 South 22nd St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 73 years.
years, months or days

3. (a) PRINT FULL NAME Ida Zohnd
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 Widowed
6. (b) Name of husband or wife Fred Zohnd 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased June 4 1867
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
76 8 4 hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name John Tomlin
13. Birthplace Unknown Switzerland
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Miss Ida Zohnd

(b) Address 414 So. 22nd St.

17. (a) Burial (b) Date thereof 2-11-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Olivet Cemetery

18. (a) Signature of funeral director Herman W. Sinden

(b) Address 1802 Union St.

19. (a) 2-11-44 (b) Kore Kerp
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Buchanan
(c) City or town St. Joseph
(If outside city or town limits, write "RURAL")
(d) Street No. 414 South 22nd St.
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 8
year 1944 hour 12 minute 30 A.M.

21. I hereby certify that I attended the deceased from Jan 24
1944 to Feb 7 1944
that I last saw him alive on Feb 7 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Influenza Duration 12 days

Due to arteriosclerosis 58 yrs

Due to _____

Other conditions (Include pregnancy within 3 months of death) 330

Major findings: Of operations r

Of autopsy r

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 of physician Charles H. Kerner (M. D. or other) ✓

Address 231 Kirkpatrick Bldg Date signed 3-8-1944
St. Joseph Mo

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.....

Herman W. Sidenfaden

Licensed Embalmer No.....

12728

P. O. Address.....

St. Joseph 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 6664

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 131

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(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

Jeda Zohnd

3. (b) If veteran,
name war.

3. (c) Social Security
No.

4. Sex F
Color or race W

6. (a) Single, widowed, married,
divorced W

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
76

Months
8

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)

(Burial, cremation, or removal)

(b) Date thereof

(Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a)

(Date received local registrar)

(b)

(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) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July
year 1948 hour 10 minute 15 M.

21. I hereby certify that I attended the deceased from
19... to 19...
that I last saw him alive on
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 sta-
tistically.

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 (M. D. or other)

Address Date signed

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

SUPPLEMENTARY

