

S. No. 2  
M-8-43  
5-17-39  
X37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

28866

State File No. ....

FILED AUG 28 1944  
Registration District No. 217

Primary Registration District No. 3063

Registrar's No. 1741

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

1. PLACE OF DEATH  
(a) County St Louis  
(b) City or town Clayton  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: St Louis County Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution. 1 mo 14 days  
(Specify whether  
In this community 23 years  
years, months or days)

3. (a) PRINT FULL NAME George Zurheide  
3. (b) If veteran, name war. .... 3. (c) Social Security No. ....

4. Sex M. 5. Color or race W 6. (a) Single, widowed, married, divorced m.  
6. (b) Name of husband or wife. Ida Zurheide 6. (c) Age of husband or wife if alive. 62<sup>7</sup> years  
7. Birth date of deceased. 2 1868  
(Month) (Day) (Year)

8. AGE: Years 75 Months 9 Days 14 If less than one day hr. min.

9. Birthplace. Germany 4  
(City, town, or county) (State or foreign country)

10. Usual occupation. Chemist

11. Industry or business. Retired

MOTHER FATHER {  
12. Name. Unknown ?  
13. Birthplace. Unknown Unknown 9  
(City, town, or county) (State or foreign country)  
14. Maiden name. Unknown ?  
15. Birthplace. Unknown Unknown 9  
(City, town, or county) (State or foreign country)

16. (a) Informant. E. H. Zurheide  
(b) Address. 5004 Emerson Ave. Home

17. (a) Burial (b) Date thereof. 8-19-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation. Zions Cemetery

18. (a) Signature of funeral director. Drehmann-Harral  
(b) Address. 1905 Union Blvd.

19. (a) AUG 18 1944 (b) E. W. McHarran, M.D.  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State. Missouri (b) County. St Louis 96  
(c) City or town. St. Bernard 96  
(If outside city or town limits, write "RURAL")  
(d) Street No. Natural Bridge 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 Aug day 16  
year 1944 hour. 12:01 minute PM M.  
21. I hereby certify that I attended the deceased from July  
2, 1944, to 8-16, 1944  
that I last saw him alive on 8-16, 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death. Cardiac failure 2 days  
Due to. Syphilis - undetermined 30 g  
Due to. Cepititis weeks  
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)  
(d) 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. James Cornish (M. D. or opt.)  
Address. St. Louis Co Hospital Date signed 8-18-44

**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..... *Albert M. Thompson*.....

Licensed Embalmer No. *4237*.....

P. O. Address..... *St. Louis*.....

**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.**