

7. S. No. 2
OM-8-43
ev. 5-17-39
X37823

FILED JAN 20 1945

318

State File No. _____

Registration District No. _____ Primary Registration District No. 1002 Registrar's No. 290

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:
3639a Garfield Ave.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether
years, months or days)

In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 3639a Garfield Ave.
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Bertie A. Zahner

3. (b) If veteran, name war Nil 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Divorced

6. (b) Name of husband or wife Henry Zahner 6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased June 20 1881
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>63</u>	<u>6</u>	<u>9</u>	hr. _____ min.

9. Birthplace Perry County Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Sam Clifton

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

14. Maiden name Susan Wells

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

16. (a) Informant Eva Robison

(b) Address 3639a Garfield Ave.

17. (a) Burial (b) Date thereof 1-12-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Perryville, Missouri

18. (c) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) JAN 10 1945 (Date received local registrar)
J. F. Bruck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 9
year 1945 hour 12:30 minute A. M.

21. I hereby certify that I attended the deceased from July 1944 to Jan 9 - 1945

that I last saw her alive on Jan 7 1945
and that death occurred on the date and hour stated above.

Immediate cause of death chronic myocardi Duration _____

Due to Chronic Myocarditis

Due to _____

Other conditions (include pregnancy within 3 months of death) 12/1

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)

Means of injury _____

23. Signature J. F. Bruck (M. D. or other) _____
Address 7901 W. Newstead Date signed 1/11/45

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 *W. W. Wilkins*
Licensed Embalmer No. 3575

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.