

FILED MAR 9 1945

318

Primary Registration District No. 1003

Registrar's No. 1686

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:
1721 Ofallen Str
(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 Mo (b) County 17
(c) City or town St Louis (If outside city or town limits, write "RURAL")
(d) Street No. 1721 Ofallen str.
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Ollie Zacheis

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

4. Sex Female 5. Color White 6. (a) Single, widowed, married, divorced, Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased August 22 1877
(Month) (Day) (Year)

8. AGE: Years 67 Months 5 Days 27 If less than one day hr. min.

9. Birthplace Mascoutah, Ill.
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife at home

11. Industry or business _____

MOTHER FATHER { 12. Name Zonrad Zacheis
13. Birthplace Latham, Ill.
(City, town, or county) (State or foreign country)
14. Maiden name Mary Zacheis
15. Birthplace Switzerland
(City, town, or county) (State or foreign country)

16. (a) Informant Nova Bupky
(b) Address 1721 Ofallen Str.

17. (a) Burial (b) Date thereof 2-21-45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation New St. Marcus Central Und Co.

18. (a) Signature of funeral director J. F. Bieder
(b) Address 1841 Cass Ave.

19. (a) FEB 20 1945 (b) _____
(Date received local health officer) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 18 year 1945 hour 6 minute 15 P.M.
21. I hereby certify that I attended the deceased from 15 191943 May 16 1948
that I last saw her alive on Feb 14 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis Duration 2 yrs
Due to arterio sclerosis 18 yrs

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)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

(Specify type of place) _____
While at work? (c) Means of injury _____
23. Signature A. Basil Parr (M. D. or other) _____
Address 1730 Franklin Ave Date signed 2-19-45

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..... *John Agonicki*
Licensed Embalmer No. *3398*
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.