S. No. 2
M—2-43
5-17-39
P1 X35657

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 9 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 15747

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 4706

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: Luthren Hospital 0 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution one day (Specify whether

In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 004

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

(d) Street No. 2710 S. Grand Ave 16 (If rural, give location)

(e) Citizen of foreign country? No 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME John F. Zunt

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

4. Sex Male 0

5. Color or race Wht.

6. (a) Single, widowed, married, divorced Wid. 9

6. (b) Name of husband or wife Mary Zunt

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Unknown (Month) Abt. (Day) 1898 (Year)

8. AGE: Years About 47 Months Unknown Days If less than one day hr. min.

9. Birthplace (City, town, or county) St. Louis, Mo. 0 (State or foreign country)

10. Usual occupation

11. Industry or business

FATHER
12. Name Joseph Zunt 1
13. Birthplace (City, town, or county) Czechoslovakia (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace (City, town, or county) Unknown 4 (State or foreign country)

16. (a) Informant Mary Krutisch

(b) Address 3322 Ohio Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/29/45 (Month) (Day) (Year)

(c) Place: burial or cremation Old S.S. Peter & Paul

18. (a) Signature of funeral director W. E. Moyall

(b) Address 1926 Allen Ave

19. (a) MAY 28 1945 (Date received local registrar) (b) J. T. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 26 year 1945 hour 7 minute 45 P. M.

21. I hereby certify that I attended the deceased from May 25 1945 to May 26 1945 that I last saw him alive on May 26 1944 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Meningococcic Septicemia	
General Purpura	1 day
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

6

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 Eleanor Bonnot (M. D. ~~or other~~)

Address 1504 So. Grand Date signed 5/26/45

(Licensed Embalmer's Statement on Reverse Side)

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 me

....., Registered Apprentice No.....,

working under my personal supervision.

Signed D. M. Davis

Licensed Embalmer No. 3741

P. O. Address 1926 Allen

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.

No. 2B
-3-45
1 X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. June 4706

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

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:
(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

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

3. (a) PRINT FULL NAME John F. Zurt
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 Wid
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Mch (Month) (Day) (Year)
8. AGE: Years alt 47 Months Days If less than one day hr. min.
9. Birthplace Mo (City, town, or county) (State or foreign country)
10. Usual occupation Beer Bottler
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 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) JUN 13 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

SUPPLEMENTARY

20. DATE OF DEATH: Month Day year hour minute 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 — 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 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 (M. D. or other)
Address Date signed

15747