

S. No. 2
FORM-2-43
Rev. 5-17-39
X35697

26304

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED AUG 24 1945

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **6593**

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:
2005 S. 3 Str. /
(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 **Mo.** (b) County **060**

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

(d) Street No. **2005 S. 3 Str.**
(If rural, give location)

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

3. (a) PRINT FULL NAME **Samuel Vernon Zellers**

3. (b) If veteran, name war **No**

3. (c) Social Security No. **----**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug.** day **6**
year **1945** hour **10** minute **P.** M.

4. Sex **Male** 5. Color or race **Wht.**

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 **Aug. 31 1930**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **June 25th,** 19 **45** to **Aug. 6th,** 19 **45**
that I last saw him alive on **July 25th** 19 **45**
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	14	11	5	hr. _____ min.

Immediate cause of death **Mitro Inefficiency** **1 Day**

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

10. Usual occupation **At School**

11. Industry or business _____

Due to _____

Due to _____

12. Name **Harry R. Zellers**

13. Birthplace **Indiana /**
(City, town, or county) (State or foreign country)

14. Maiden name **Eithia Clayton**

15. Birthplace **Rolla Mo. 1**
(City, town, or county) (State or foreign country)

Other conditions **Cardiac Decomposition**
(Include pregnancy within 3 months of death) **2 Mo.**

and enlargement of heart

16. (a) Informant **Harry R. Zellers**

(b) Address **2005 S. 3 Str.**

17. (a) **Burial** (b) Date thereof **7/10/45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mt. Hope cemetery**

Major findings:
Of operations _____

Of autopsy **no**

18. (a) Signature of funeral director **Stan E. Moyall**

(b) Address **1926 Allen Ave.**

19. (a) **AUG 9 1945** (Date received by Registrar)
J. F. Bredack (Registrar's signature)

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 **Dr. W. H. Matter** (M. D. or other)
Address **3608 S. Grand Blvd.** Date signed **8/8/45**

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..... *Benj. L. Duncan*

Licensed Embalmer No. *2272*

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.