

STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED DEC 21 1945 318

Registration District No. _____

Primary Registration District No. _____

1003

Registrar's No. 10656

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:
3017 Keokuk Street
(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)

3. (a) PRINT FULL NAME Frank Joseph Zorn

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

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

6. (b) Name of husband or wife Katherine 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased July 26 1863
(Month) (Day) (Year)

8. AGE: Years 82 Months 4 Days 11 If less than one day hr. _____ min.

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

10. Usual occupation Retired

MOTHER FATHER { 11. Industry or business _____
12. Name Unknown
13. Birthplace Unknown
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Jacob Zorn
(b) Address 3017 Keokuk St.

17. (a) Burial (b) Date thereof Dec. 10, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Old S S Peter & Paul

18. (a) Signature of funeral director Wacker Helderle
(b) Address 3624 Travis

19. (a) DEC 8 1945 (b) g. F. Budeak
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 3017 Keokuk St.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 7
year 1945 hour 5 minute 30 A. M.

21. I hereby certify that I attended the deceased from War
7th 1940 to Dec 1 1945
that I last saw him alive on Dec 6th 1945
and that death occurred on the date and hour stated above.

Immediate cause of death: Parenchymatous degeneration

Due to Smile & obesity 18 months

Due to _____

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: ✓ Of operations: 120
Of autopsy: ✓

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)
(e) Means of injury _____
23. Signature Albert J. Gubhardt (M. D. or other)
Address 2445 Chippewa Date signed 12/7/45

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 Robert O'Connell

Licensed Embalmer No. 2178

P. O. Address St. Louis, Mo.

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.