2
-43
-39
36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 9 1946

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 29242

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7308

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: Enroute City Hospital 3
(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 Indiana (b) County 999

(c) City or town Evansville 12
(If outside city or town limits, write "RURAL")

(d) Street No. 514 Hess Ave. NRO
(If rural, give location)

(e) Citizen of foreign country? (Yes or No) 2

If yes, name country

3. (a) PRINT FULL NAME Bernard Zeller

3. (b) If veteran, name war No

3. (c) Social Security No. Unknown

4. Sex Male 1

5. Color or race White

6. (a) Single, widowed, married, divorced Widower

6. (b) Name of husband or wife Catherine Zeller

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

7. Birth date of deceased Feb. (Month) 24 (Day) 1882 (Year)

8. AGE: Years 64 Months 5 Days ~~28~~ 27 If less than one day hr. min.

9. Birthplace St. Wendell (City, town, or county) Indiana (State or foreign country) 1

10. Usual occupation Retired

11. Industry or business

FATHER
12. Name Peter Zeller 9
13. Birthplace Unknown (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country) 9

16. (a) Informant Bernard P. Zeller
(b) Address Evansville, Ind.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 8-22-46 (Month) (Day) (Year)
(c) Place: burial or cremation Evansville, Ind.

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.

19. (a) AUG 22 1946 (Date received local registrar) J. J. Biedrich (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 21 year 1946 hour 8 minute 0 M.

21. I hereby certify that I attended the deceased from 2, 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 External Hemorrhage

Due to from Carcinoma of Larynx

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

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 3

23. Signature Dr Alfred J Perry (M.D. or other)

Address Dey Sanatorium Date signed 8/22/46

(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.....

....., Registered Apprentice No....., working under my personal supervision.

Signed J. Allen Davis Jr

Licensed Embalmer No. 4053

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.

o. 2B
-3-45
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. Sept

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7308

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 Bernard Feller

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 Jet 24 1880
(Month) (Day) (Year)

8. AGE: Years 64 Months 5 Days 2 If less than one day hr. min.

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

10. Usual occupation

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) 8-22-46 (Date received by local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug Day 21 year 1946 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

SUPPLEMENTARY

OCT 15 1946

29242