

U. S. No. 2
OM-5-43
Rev. 5-17-39
No. 1 X38671

State File No. _____

FILED JAN 17 1947

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **2**

1. PLACE OF DEATH:

(a) County _____

(b) City or town _____
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
1929 N. Florissant
(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 **Joseph Zichler**

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

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

6. (a) Single, widowed, married, divorced **M**

6. (b) Name of husband or wife **Marie**

6. (c) Age of husband or wife if alive **75** years

7. Birth date of deceased **March 22 1865**
(Month) (Day) (Year)

8. AGE: Years **83** Months **9** Days **10** If less than one day _____ hr. _____ min.

9. Birthplace **Germany** (City, town, or county) (State or foreign country) **4**

10. Usual occupation **None**

11. Industry or business _____

MOTHER FATHER { 12. Name **Joseph Zichler**

13. Birthplace **Germany** (City, town, or county) (State or foreign country) **4**

14. Maiden name **Marie Zichler**

15. Birthplace **Germany** (City, town, or county) (State or foreign country) **4**

16. (a) Informant **Mary Zichler**

(b) Address **1929 N Florissant**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **1/4/47** (Month) (Day) (Year)

(c) Place: burial or cremation **Oak Hill Cemetery**

18. (a) Signature of funeral director **Central Und. Co.**

(b) Address **1841 Cass ave**

19. (a) **JAN 2 47** (Date received local registry) (b) **J. F. Bredek** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County _____

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

(d) Street No. **1929 Florissant Blvd**
(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan** day **2**, year **1947** hour **8:40** minute **1** A. M.

21. I hereby certify that I attended the deceased from **Dec. 22 1946** to **Jan. 2 1947**, that I last saw him alive on **Jan. 1 1947**, and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary Insufficiency**

Due to _____

Due to _____

Other conditions **Anemia, Secondary**
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

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) (c) Means of injury _____

23. Signature **O. E. Tjoflat** (M. D. or other) **MD**

Address **4222 N. Grand** Date signed **1-2-47**

Duration

6 wks

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 W. W. Wilkinson

Licensed Embalmer No. 3575

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.