

FILED MAR 7 1947

State File No. _____

Registration District No. 170

Primary Registration District No. 3033

Registrar's No. _____

1. PLACE OF DEATH: *Ladde*
 (a) County *Ladde*
 (b) City or town *Ladde*
 (c) Name of hospital or institution: *Wallace Memorial Hospital*
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution *12 hrs*
 In this community _____
 years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State *Missouri* (b) County *Dallas*
 (c) City or town *Buffalo*
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME *Minnie E. Zimmerman*
 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month *Feb.* day *19-4*
 year *1947* hour *12:00* minute *7:00* M.

4. Sex *Female* 5. Color or race *W.*
 6. (a) Single, widowed, married, divorced *Married*
 6. (b) Name of husband or wife *Elmer Zimmerman* 6. (c) Age of husband or wife if alive *56* years
 7. Birth date of deceased: *Aug - 13 - 1891*
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from *2-18*, 1947, to *2-19*, 1947;
 that I last saw him alive on *2-19*, 1947;
 and that death occurred on the date and hour stated above.

8. AGE: Years *53* Months *6* Days *6*
 If less than one day _____ hr. _____ min.

Immediate cause of death *Accidental*
traumatism by crushed
chest in auto accident
 Duration *12 hours*

9. Birthplace *Dallas Co. Mo*
 (City, town, or county) (State or foreign country)

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

MOTHER FATHER
 11. Industry or business _____
 12. Name *Robert Rhoadlander*
 13. Birthplace *Dallas Co. Mo*
 (City, town, or county) (State or foreign country)
 14. Maiden name *Etha Hatfield*
 15. Birthplace *Dallas Co. Mo*
 (City, town, or county) (State or foreign country)

Major findings: *MI*
 Of operations _____
 Of autopsy _____
 PHYSICIAN _____
 -Underline the cause to which death should be charged statistically.

16. (a) Informant *John Zimmerman*
 (b) Address *Buffalo Mo*
 17. (a) *Burial* (b) Date thereof *Feb - 20 - 47*
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation *New Hope*
 18. (a) Signature of funeral director *W. B. Jones*
 (b) Address *Buffalo Mo*
 19. (a) *March 1, 1947* (b) *Dr. Gumburger*
 (Date entered local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) *Accident*
 (b) Date of occurrence *2-18-47*
 (c) Where did injury occur? *Ladde Mo*
 (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
3 miles W. of Ladde on U.S. Highway 104
 While at work? *no* (Specify type of place) (e) Means of injury *Auto accident*
 23. Signature *R. E. Hanell* (M. D. or other) *M.D.*
 Address *Ladde, Mo* Date signed *2-19-47*

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

Received 3/5/47
Laclede County Health Unit
File No. 2/47/27
Date Filed 3/5/47

APR 4 1947

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 Leonard Blum

Licensed Embalmer No. 2508

P. O. Address Buffalo 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.