S. No. 2
4—1/47
. 5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED DEC 6 1947 318
Registration District No.

#38783

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 40363
Registrar's No. 10924

1. PLACE OF DEATH:
(a) County
(b) City or town St.Louis,Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: City Hospital
(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 Missouri (b) County
(c) City or town St.Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 5419 Genevieve Ave.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

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3. (a) PRINT FULL NAME ROSE ZELLWEGER
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex female
5. Color or race white
6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife Adolph Zellweger
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Nov. (Month) 26th (Day) 1874 (Year)

8. AGE: Years	Months	Days	If less than one day
73	0	1	hr. min.

9. Birthplace New Jersey (City, town, or county) (State or foreign country)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name ---- Kilburtz
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)
16. (a) Informant Hope Lindauer
(b) Address 4883 Farlin Ave.
17. (a) burial (Burial, cremation, or removal) (b) Date thereof 11-29-47 (Month) (Day) (Year)
(c) Place: burial or cremation Summerfield, Ill.
18. (a) Signature of funeral director Calvin F. Feutz
(b) Address 4828 Natural Bridge
19. (a) NOV 29 1947 (Date received local registrar) (b) J. F. Broeck (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Nov. day 27th
year 1947 hour 9:45 minute A M.
21. I hereby certify that I attended the deceased from 9/25/47
to Nov. 27th 1947;
that I last saw him alive on Nov. 27th 1947;
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Chronic Pyelonephritis (Calculus) RX.	3 yrs
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN
Underline the cause of 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 Tallcoman M.D. (M. D. or other)
Address 1515 Lafayette Date signed 11/28/47

Jefferson City Printing Co.
(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 John A. Mlinar

Licensed Embalmer No. 4186

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.