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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

STANDARD CERTIFICATE OF DEATH

State File No. 43889

FILED DEC 31 1947

Registration District No. 1947 — Primary Registration District No. 6076 — Registrar's No. 2697

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution: Robert Koch Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 964 days (Specify whether years, months or days)

In this community 4 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

(c) City or town St. Louis (If outside city or town limits, write "RURAL") 17

(d) Street No. 4148 Lexington (If rural, give location) 9

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

If yes, name country

3. (a) PRINT FULL NAME ZOELLNER, FLORA CLARA

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Clarence William Zoellner

6. (c) Age of husband or wife if 43 years

7. Birth date of deceased May (Month) 28 (Day) 1903 (Year)

8. AGE: Years 44 | Months 6 | Days 26 | If less than one day ..... hr. ..... min.

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

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Emil Meister
13. Birthplace Perry Co. (City, town, or county) Missouri (State or foreign country)

MOTHER
14. Maiden name Bertha Pohlmann
15. Birthplace Bollinger (City, town, or county) Missouri (State or foreign country)

16. (a) Informant Hospital Records

(b) Address Robert Koch Hospital

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-27-47 (Month) (Day) (Year)

(c) Place: burial or cremation Uniontown, Mo.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) 12-26-47 (Date received local registrar) (b) Cecil A. Shay (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 24 year 1947 hour 7 minute 00 A. M.

21. I hereby certify that I attended the deceased from 5-4-45, 19..., to 12-24-47, 19...; that I last saw her alive on 12-24-, 1947; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Pulmonary Tuberculosis	4½ yrs. (??)
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

13 b

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 Bernard Friedman (M. D. or other) M.D.

Address Koch Hosp., Koch, Mo. Date signed 12-24-47

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 J. Allen Davis

Licensed Embalmer No. 4053

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.