

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **21829**BUREAU OF THE CENSUS
FILED JUL 15 1948Registration District No. **324**Primary Registration District No. **3072**Registrar's No. **139**

1. PLACE OF DEATH:

(a) County **Saline**
 (b) City or town **Marshall, Mo.**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: **Fitzgibbons Hospital**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **8 Days**
 (Specify whether years, months or days)
 In this community **32 Years**

3. (a) PRINT

FULL NAME **Kate Viola Zimmerman**

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 **Married**6. (b) Name of husband or wife **Fred R. Zimmerman**6. (c) Age of husband or wife if
alive **62** years7. Birth date of deceased **July 16 1895**

(Month)

(Day)

(Year)

8. AGE:

Years
52Months
11Days
15

If less than one day

hr. min.

9. Birthplace **California**

(City, town, or county)

Mo.

(State or foreign country)

10. Usual occupation **House Wife**

11. Industry or business

12. Name **George Sanders**13. Birthplace **California**

(City, town, or county)

Mo.

(State or foreign country)

14. Maiden name **Betty Dobson**15. Birthplace **California**

(City, town, or county)

Mo.

(State or foreign country)

16. (a) Informant **Fred R. Zimmerman**(b) Address **Napton Mo. R.F.D.**17. (a) **Burial**

(Burial, cremation, or removal)

(b) Date thereof **7/2/48**

(Month) (Day) (Year)

(c) Place: burial or cremation **Arrow Rock Cemetery**

18. (a) Signature of funeral director

(b) Address

19. **July 1-1948**

(Date received local registrar)

(b) **Andrew W. Gray**

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Saline**
 (c) City or town **Napton**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **Rural - R.F.D. 1**
 (If rural, give location)
 (e) Citizen of foreign country? **No.** (Yes or No)
 If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **1** or
 year **1948** hour **7:12** minute **15** A. M.

21. I hereby certify that I attended the deceased from
June 23 19**48** to **June 30** 19**48**
 that I last saw him alive on **June 30** 19**48**
 and that death occurred on the date and hour stated above.

Immediate cause of death

Acute Peritonitis
Ruptured Appendix
Acute Scurvy
Suppression of urine

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?

While at work? (Specify type of place)
 (c) Means of injury

23. Signature **Lawless & Haynes** (M. D. or other)Address **Marshall Mo** Date signed **7-1-48**

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 7-14-68

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.....

Licensed Embalmer No. 3235

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.