

FILED FEB 14 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 359

BIRTH NO. _____		REG. DIST. NO. 42		PRIMARY REG. DIST. NO. 1000		Registrar's No. 179	
1. PLACE OF DEATH a. COUNTY Buchanan				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Missouri b. COUNTY Buchanan			
b. CITY (If outside corporate limits, write RURAL and give township) St. Joseph, Mo.				c. CITY (If outside corporate limits, write RURAL and give township) St. Joseph, Mo.			
d. FULL NAME OF HOSPITAL OR INSTITUTION 2909 Monterey St.				d. STREET ADDRESS (If rural, give location) 2909 Monterey St.			
3. NAME OF DECEASED (Type or Print)		a. (First) Reynold		b. (Middle) Albert		c. (Last) Zeorlin	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWER, DIVORCED (Specify) Married		8. DATE OF BIRTH July 17, 1895	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Swift & Co.		11. BIRTHPLACE (State or foreign country) St. Joseph, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Charles Zeorlin		13b. MOTHER'S MAIDEN NAME Louise Weidman		14. NAME OF HUSBAND OR WIFE Lillian			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknowns) No		16. SOCIAL SECURITY NO. 487-05-1400		17. INFORMANT'S SIGNATURE OR NAME Mrs Lillian Zeorlin 2909 Monterey			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) entered scl. gen DUE TO (c) 53 17 II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Hypertension INTERVAL BETWEEN ONSET AND DEATH 3 yrs - 3 yrs -			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 6			
22. I hereby certify that I attended the deceased from 7/6, 1896, to 2/1, 1949, that I last saw the deceased alive on 2/1, 1949, and that death occurred at 4:00 a. m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Frank H. Deagan				23b. ADDRESS 676 Francis St.		23c. DATE SIGNED 2/8/49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 2/10/1949		24c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		24d. LOCATION (City, town, or county) (State) St. Joseph, Mo.	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE Feb 10, 1949		382 E. B. Jenkins		25. FUNERAL DIRECTOR'S SIGNATURE Norman W. Siderfaden		ADDRESS 1802 Union St.	

(Licensed Embalmer's Statement on Reverse Side)

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

FEB 23 1949

MAR 11 1949

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student

Student Embalmer

Signed _____

Robert L. Gable

Licensed Embalmer No. _____

3308

P. O. Address _____

St. Joseph, 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.