

FILED JUL 22 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 22783

BIRTH NO. _____		REG. DIST. NO. <u>53</u>		PRIMARY REG. DIST. NO. <u>3010</u>		Registrar's No. <u>224</u>	
1. PLACE OF DEATH a. COUNTY <u>Cape Girardeau</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cape Girardeau</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>CAPE GIRARDEAU</u>		c. LENGTH OF STAY (In this place) <u>2 wks</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Byrd</u>		16 <u>01</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Francis Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>Near Jackson</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>JOHANNA</u>			b. (Middle) _____		c. (Last) <u>ZSCHILLE</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>July 4 1949</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Jan. 17-1868</u> <u>July 4 1949</u>	9. AGE (In years last birthday) <u>86</u>	IF UNDER 1 YEAR Months <u>5</u> Days <u>17</u>	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTH PLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Chris Lower</u>		13b. MOTHER'S MAIDEN NAME <u>Marie Keiser</u>		14. NAME OF HUSBAND OR WIFE <u>Reinhardt Zschille Deek</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Fred Zschille, Jackson, Mo</u>			
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____  DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.  <u>331X</u>				INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 29, 1949</u> , to <u>July 4, 1949</u> , that I last saw the deceased alive on <u>July 4, 1949</u> , and that death occurred at <u>5:20 p.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>C. F. McDonald, M.D.</u>				23b. ADDRESS <u>Jackson, Mo.</u>		23c. DATE SIGNED <u>7-6-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>7-6-49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Jackson City</u>		24d. LOCATION (City, town, or county) (State) <u>Jackson, Mo.</u>		
DATE REC'D BY LOCAL REG. <u>7-11-1949</u>		REGISTRAR'S SIGNATURE <u>C. C. Semmers</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Seaboard-Grand, Jackson, Mo.</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

REIVED 7-18-49

Health Officer No. 4

File Number 749-5

Date filed \_\_\_\_\_

**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.

Signed R.O. Laird

Signed.....  
Student Embalmer

Licensed Embalmer No. 4538

P. O. Address Jackson, 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.