

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **38403**

BIRTH NO. _____ REG. DIST. NO. **310** PRIMARY REG. DIST. NO. **3058** Registrar's No. **273**

1. PLACE OF DEATH a. COUNTY St. Charles		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Charles	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Charles		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Charles	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1118 Tompkins St.		d. STREET ADDRESS (If rural, give location) 1118 Tompkins St.	

3. NAME OF DECEASED (Type or Print)	a. (First) Mary	b. (Middle) H.	c. (Last) Zerr	4. DATE OF DEATH (Month) (Day) (Year) Nov. 22, 1949
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 2-9-1872	9. AGE (In years last birthday) 77	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours	IF UNDER 1 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) St. Peters, Mo.	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Ferdinand Ernst	13b. MOTHER'S MAIDEN NAME Mary Ernst	14. NAME OF HUSBAND OR WIFE George E. Zerr
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Ralph Zerr, 1118 Tompkins St., Charles, Mo.	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Anemia - Chronic Nephritis		4 days
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension - arteriosclerosis DUE TO (c) Chronic Hypertrophic Arteritis		? 592 X ?

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **Nov 10, 1935**, to **Nov 22, 1949**, that I last saw the deceased alive on **Nov 21, 1949**, and that death occurred at **1:30 P. m.**, from the causes and on the date stated above.

23a. SIGNATURE J. J. [Signature] (Degree or title) M.D.	23b. ADDRESS St. Charles, Mo.	23c. DATE SIGNED 11-23-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 11-25-49	24c. NAME OF CEMETERY OR CREMATORY All Saints	24d. LOCATION (City, town, or county) (State) St. Peters, Mo.
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DATE REC'D BY LOCAL REG. 11-29-49	REGISTRAR'S SIGNATURE Frank Hamilton	25. FUNERAL DIRECTOR'S SIGNATURE Rev. [Signature] ADDRESS St. Peters, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

9-2
1-4

District File Number _____
District Health Officer No. 9
RECEIVED DEC 3 1952

DEC 17 1952

MAR 2 1953

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 E. Kerthly

Signed _____
Student Embalmer

Licensed Embalmer No. 874

P. O. Address Dallas 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.