

FILED MAY 5 1950

STANDARD CERTIFICATE OF DEATH

State File No. 15150

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| BIRTH NO. _____ | | REG. DIST. NO. _____ | | PRIMARY REG. DIST. NO. _____ | | Registrar's No. _____ | | | |
| 1. PLACE OF DEATH a. COUNTY _____ | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>mo</u> b. COUNTY _____ | | | | | |
| b. CITY (If outside corporate limits, write RURAL and give town) <u>St Louis</u> | | c. LENGTH OF STAY (in this place) _____ | | c. CITY (If outside corporate limits, write RURAL and give township) <u>St Louis</u> | | 2189 | | | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St Johns Hospital</u> | | | | 10. STREET ADDRESS (If rural, give location) <u>4400 (Rear) Vista</u> | | | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) <u>Charles</u> | | b. (Middle) <u>F</u> | | c. (Last) <u>Zimmer</u> | | 4. DATE OF DEATH (Month) (Day) (Year) <u>4-30-1950</u> | | | |
| 5. SEX <u>male</u> | | 6. COLOR OR RACE <u>white</u> | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u> | | 8. DATE OF BIRTH <u>about 68</u> | | | |
| 9. AGE (In years last birthday) _____ | | IF UNDER 1 YEAR Months _____ | | IF UNDER 6 HRS. Hours _____ | | IF UNDER 15 MIN. Min. _____ | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Armature Winder</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Public Service</u> | | 11. BIRTHPLACE (State or foreign country) <u>St Louis mo</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | |
| 13a. FATHER'S NAME <u>John Zimmer</u> | | 13b. MOTHER'S MAIDEN NAME <u>Unknown</u> | | 14. NAME OF HUSBAND OR WIFE <u>Alice</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____ | | 16. SOCIAL SECURITY NO. _____ | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Alice Zimmer 4400 Vista</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, asthma, etc. It means the disease, injury, or complication which caused death. | | | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Bronchial Asthma</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</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. | | | | | | | | | |
| 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) <u>2411</u> | | | | | |
| 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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>11:55</u> m., from the causes and on the date stated above. | | | | | | | | | |
| 23a. SIGNATURE (Degree or title) <u>William A. Turner M.D.</u> | | | | 23b. ADDRESS <u>16 Hampton Relay Plaza</u> | | 23c. DATE SIGNED <u>4/21/50</u> | | | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24b. DATE <u>4-22-50</u> | | 24c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cem</u> | | 24d. LOCATION (City, town, or county) (State) <u>St Louis Mo</u> | | | |
| DATE REC'D BY LOCAL REG. <u>APR 24 1950</u> | | REGISTRAR'S SIGNATURE <u>J. B. Sauter</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Rowland Mortuary Service Inc.</u> 410 1/2 Manchester Ave. St. Louis 10, Mo. | | | | | |

(Licensed Embalmer's Statement on Reverse Side)

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

Dr W^m Kern
Sw 4846

3748

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 _____

working under my personal supervision.

Student Embalmer No.

Signed Howard P. Rowland

Signed.....
Student Embalmer

Licensed Embalmer No. 3114

P. O. Address St Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.