

FILED NOV 24 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **39670**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **374** PRIMARY REG. DIST. NO. **6276** Registrar's No. **50**

1. PLACE OF DEATH a. COUNTY <b>Worth</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Worth</b> <b>1130</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Rural-Union Township</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Rural-Union Township</b> <b>0</b>	
c. LENGTH OF STAY (in this place) <b>37 years</b>		d. STREET ADDRESS (If rural, give location) <b>Grant City, Mo.</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Grant City</b>			

3. NAME OF DECEASED (Type or Print)	a. (First) <b>William</b>	b. (Middle) <b>Reese</b>	c. (Last) <b>Zollman</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>11 9 1950</b>
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5. SEX <b>male 0</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>7 6 1882</b>	9. AGE (In years last birthday) <b>68</b>	IF UNDER 1 YEAR Months <b>4</b>	IF UNDER 24 HRS. Days <b>3</b>	Hours <b>0</b>	Min. <b>0</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>farmer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>farming for self</b>	11. BIRTHPLACE (State or foreign country) <b>Rockbridge County, Virginia</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>William Madison Zollman</b>	13b. MOTHER'S MAIDEN NAME <b>Ida R. Cunningham</b>	14. NAME OF HUSBAND OR WIFE <b>Martha Agnes Zollman</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs. Martha Agnes Zollman Grant City, Mo.</b>
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>3 1/2 hrs</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Multiple Neuritis -</b>		
	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. <b>Nephritis</b>		<b>3 1/2 hrs</b>	

19a. DATE OF OPERATION <input checked="" type="checkbox"/>	19b. MAJOR FINDINGS OF OPERATION <input checked="" type="checkbox"/>	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <input checked="" type="checkbox"/>	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) (Minute) <b>11 9 1950</b>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <input checked="" type="checkbox"/>
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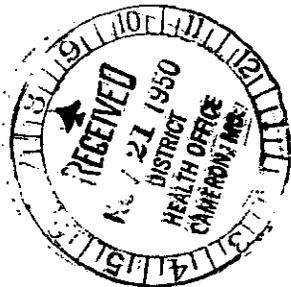
22. I hereby certify that I attended the deceased from **June 20, 1950** to **Nov 9, 1950**, that I last saw the deceased alive on **Nov 9, 1950**, and that death occurred at **9:15 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE <b>Miss M.D.</b> (Degree or title)	23b. ADDRESS <b>Grant City Mo.</b>	23c. DATE SIGNED <b>11-10-50</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>11 12 1950</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Blockton Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>Blockton, Iowa</b>
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DATE REC'D BY LOCAL REG. <b>11-15-1950</b>	REGISTRAR'S SIGNATURE <b>Netta E. Dawson</b>	345	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Grant City, Missouri</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD



**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 \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

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.