

FILED MAY 6 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

14305

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **37511**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Missouri Pacific		d. STREET ADDRESS (If rural, give location) 4021 Schiller Place	
3. NAME OF DECEASED a. (First) EDMUND b. (Middle) AUGUST c. (Last) ZELL		4. DATE OF DEATH (Month) (Day) (Year) Apr 28 '54	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Sept 25 1908
9. AGE (In years last birthday) 45		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rate Clerk	11. BIRTHPLACE (State or foreign country) St. Louis Mo
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rate Clerk		10b. KIND OF BUSINESS OR INDUSTRY Railroad	12. CITIZEN OF WHAT COUNTRY?
13a. FATHER'S NAME August W Zell		13b. MOTHER'S MAIDEN NAME Lillie A Kerwin	14. NAME OF HUSBAND OR WIFE Helen Zell
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Helen Zell ADDRESS 4021 Schiller Pl
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) Subarachnoid hemorrhage ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Malignant hypertension 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 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) 330X			
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?			
22. I hereby certify that I attended the deceased from Mar 20, 1954 , to April 23, 1954 , that I last saw the deceased alive on April 23, 1954 , and that death occurred at 8:23 a.m. , from the causes and on the date stated above.			
23a. SIGNATURE Edward J. Schnur (Degree or title) M.D.		23b. ADDRESS Mo. Pacific Hosp.	
23c. DATE SIGNED 4-24-54			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Apr 27 54	
24c. NAME OF CEMETERY OR CREMATORY Calvary		24d. LOCATION (City, town, or county) (State) St. Louis Mo	
DATE REC'D BY LOCAL REG. APR 26 1954		REGISTRAR'S SIGNATURE J. Carl Smith ADDRESS E. J. Schnur 3125 Lafayette	
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS			

(Licensed Embalmer's Statement on Reverse Side)

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.....

Thomas R. Fenwick

Signed.....

Student Embalmer

Licensed Embalmer No. 3793

P. O. Address 3125 Lafayette

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

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