

FILED JUL 2 - 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

21513

State File No. _____

Registrar's No. 5791

BIRTH NO. _____		REG. DIST. NO. 918		PRIMARY REG. DIST. NO. 1003		Registrar's No. 5791			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri				b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION 2609 So. Grand				1. STREET ADDRESS (If rural, give location) 2609 South Grand Blvd.				2177	
3. NAME OF DECEASED (Type or Print) a. (First) Frank			b. (Middle) William			c. (Last) Zoeller			
4. DATE OF DEATH (Month) (Day) (Year) June 26, 1954									
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED Widowed	8. DATE OF BIRTH Aug 28, 1883		9. AGE (In years last birthday) 70	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 YEAR Hours	IF UNDER 1 YEAR Mins.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Man		10b. KIND OF BUSINESS OR INDUSTRY Memorial Home		11. BIRTHPLACE (City and State or Foreign Country) New Athens, Illinois			12. CITIZEN OF WHAT COUNTRY? U.S.A		
13a. FATHER'S NAME Francis Zoeller			13b. MOTHER'S MAIDEN NAME Helena Strutz			14. NAME OF HUSBAND OR WIFE Lena Zoeller dec'd			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Nil		17. INFORMANT'S SIGNATURE OR NAME Unknown		ADDRESS _____			
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, asphyxia, etc. It means the disease, injury, or complication which caused death.	<p align="center">MEDICAL CERTIFICATION</p> <p>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Chronic advanced myocarditis</i></p> <p>ANTECEDENT CAUSES <i>Morbid conditions, if any, giving rise to the above cause (c) stating the underlying cause last.</i></p> <p>DUE TO (b) <i>Arterio-sclerosis - Hypertension</i></p> <p>DUE TO (c) _____</p> <p>II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i></p>							<p>INTERVAL BETWEEN ONSET AND DEATH <i>many weeks</i> <i>weeks</i></p>	
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 Dec 20, 1953, to Feb 19, 1954, that I last saw the deceased alive on June 19, 1954, and that death occurred at 10:45 p.m., from the causes and on the date stated above.									
23a. SIGNATURE <i>Frazer R. Ritchie M.D.</i> (Degree or title)				23b. ADDRESS 5233 West Union Av.				23c. DATE SIGNED 6-28-54	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 6-28-54		24c. NAME OF CEMETERY OR CREMATORY St. Ephast Cemetery		24d. LOCATION (City, town, or county) (State) Hecker, Illinois			
DATE REC'D BY LOCAL REC. JUN 28 1954		REGISTRAR'S SIGNATURE <i>Carl Smith</i>			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe, 4700 Washington				

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.....
Signature of Student Embalmer

Signed *Robert M. Murray*.....

3749
Licensed Embalmer No.....

P. O. Address, *St Louis*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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