

FILED SEP 21 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

32358

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 7825

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY	
b. CITY OR TOWN <u>ST. LOUIS MO</u>	c. LENGTH OF STAY (in this place)	c. CITY OR TOWN <u>ST. LOUIS</u>	d. Is Residence within limits of a city of incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ST. ANTHONY HOSPITAL</u>		e. STREET ADDRESS (If rural, give location) <u>2406 MENARD</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>ANNA</u>	b. (Middle)	c. (Last) <u>ZACH</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>AUG 23 1954</u>
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5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOW</u>	8. DATE OF BIRTH <u>OCT 12 1885</u>	9. AGE (In years last birthday) <u>68</u>	IF UNDER 1 YEAR Months Days	IF UNDER 2 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WIDOW</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>MISSOURI</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			

13a. FATHER'S NAME <u>WILLIAM ADE</u>	13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	14. NAME OF HUSBAND OR WIFE <u>WILLIAM ZACH (DEC'D)</u>
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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)	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>EVERT TOMASEK 2406 MENARD</u>
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>ARTERIOSCLEROTIC HEART DISEASE WITH HYPERTENSION</u>		<u>ABOUT 6 YRS.</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>ARTERIOSCLEROSIS GENERALIZED</u> DUE TO (c)		<u>DNK</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>DIABETES MELLITUS</u>		<u>DNK</u>	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>4200</u>
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22. I hereby certify that I attended the deceased from NOV 23 1952, to AUG 23 1954, that I last saw the deceased alive on AUG 23 1954, and that death occurred at 5:30 A.M., from the causes and on the date stated above.

23a. SIGNATURE <u>Henry T. Cooper</u> (Degree or title) <u>M.D.</u>	23b. ADDRESS <u>518 OLIVE ST.</u>	23c. DATE SIGNED <u>8/24/54</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>AUG 25 1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>S.S. PETER + PAUL</u>	24d. LOCATION (City, town, or county) (State) <u>ST. LOUIS MO</u>
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DATE REC'D BY LOCAL REGISTRAR <u>AUG 24 1954</u>	REGISTRAR'S SIGNATURE <u>J. Carl Smith M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Thomas Kutin 2906 Grand</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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MON

- 211 / - 4747

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 *James C. Hill*

Licensed Embalmer No. *4347*

P. O. Address *2906 J*

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.