

FILED OCT 15 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29954

State File No.

BIRTH NO.		REG. DIST. NO. 42		PRIMARY REG. DIST. NO. 1000		Registrar's No. 1093	
1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Andrew</u>			
b. CITY OR TOWN <u>St. Joseph</u>		c. LENGTH OF STAY (in this place) <u>3 DAYS</u>		c. CITY OR TOWN <u>SAVANNAH RURAL</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Missouri Methodist Hosp.</u>				STREET ADDRESS (If rural, give location) <u>A.F.D. 2</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>EMMA</u>		b. (Middle) <u>Zimmerman</u>		c. (Last) <u>Zimmerman</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Oct 6-1956</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>April 3-1894</u>	
9. AGE (In years last birthday) <u>62</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>AMAZONIA MO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Jacob Schrier</u>		13b. MOTHER'S MAIDEN NAME <u>Madjalene Ordnung</u>		14. NAME OF HUSBAND OR WIFE <u>Hammer Zimmerman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Hammer Zimmerman</u> ADDRESS <u>A.F.D. 2</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <u>This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</u>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Intra pontine hemorrhage</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Rupture of pontine artery</u> DUE TO (c) <u>Hypertensive Vascular Disease</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 days</u> <u>?</u>	
19. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		33/X	
21a. ACCIDENT (Specify) <u>Stroke</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		21f. HOW DID INJURY OCCUR?	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>10/4</u> , 19 <u>56</u> , to <u>10/6</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10/6</u> , 19 <u>56</u> , and that death occurred at <u>4:45 p.m.</u> , from the causes and on the date stated above.							
23. SIGNATURE <u>Daryl A. Tetter</u>		23b. ADDRESS <u>Phys Surg Bldg. St. Joseph, Mo.</u>		23c. DATE SIGNED <u>10-7-56</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>10-7-56</u>		24c. NAME OF CEMETERY OR CREMATORY <u>SAVANNAH</u>		24d. LOCATION (City, town, or county) (State) <u>SAVANNAH MO</u>	
DATE REC'D BY LOCAL REG. <u>Oct 10, 1956</u>		REGISTRAR'S SIGNATURE <u>Ethel M. Allison</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Breit Funeral Home</u> ADDRESS <u>SAVANNAH MO</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

708 84 NOV

NOV 8 1908

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.....

Licensed Embalmer No. 2650

P. O. Address Savannah

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.