

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40680

STATE FILE NUMBER

FILED DEC 17 1956

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1308

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Joseph Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph's Hospital Length of stay in 1b 24 years		d. STREET ADDRESS (If outside, give location) 1409 Olive St. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) ZACK First VAN ZANDT Middle LAST			4. DATE OF DEATH Dec. 7, 1956 Month Dec. Day 7 Year 1956		
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5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 17, 1880	9. AGE (In years last birthday) 76	IF UNDER 1 YEAR Months 0 Days 17 Hours 0 Min.	IF UNDER 24 HRS. Hours 0 Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. fireman	10b. KIND OF BUSINESS OR INDUSTRY Candy Co.	11. BIRTHPLACE (City and state or country) Williamson County, Ill.	12. CITIZEN OF WHAT COUNTRY? USA
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13. FATHER'S NAME unknown	14. MOTHER'S MAIDEN NAME unknown
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) no	16. SOCIAL SECURITY NO. 491-10-9482	17. INFORMANT Mrs. Pauline Wood, 1409 Olive St. Joseph, Mo. Address
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure		INTERVAL BETWEEN ONSET AND DEATH. 2 weeks
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Gastric Ulcers		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
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20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION St. Joseph, Missouri	STATE
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21. I attended the deceased from 11/19/56 to 12/7/56 and last saw him alive on 12/6/56 Death occurred at 3:40p. m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE Quinn Wilson MD (Degree or title)	22b. ADDRESS Tootle Building St. Joseph, Missouri	22c. DATE SIGNED 12/8/56
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23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 12/10/1956	23c. NAME OF CEMETERY OR CREMATORY Ashland Cemetery	23d. LOCATION (City, town, or county) (State) St. Joseph, Mo.
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24. FUNERAL DIRECTOR Heston-Bowman St. Joseph, Mo. ADDRESS	25. DATE RECD. BY LOCAL REG. Dec 12, 1956	26. REGISTRAR'S SIGNATURE Kathleen M. Allison
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(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare and Public Service
 300 1-56
 All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. No symptoms will be listed. All standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was by me, or by, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *James B. Hawkin*.....

Licensed Embalmer No. *452*.....

P. O. Address *319 E. 10th St.*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. 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.