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-56

Director, coroner, etc. must use only standard nomenclature in Part 18. No symptoms with no assigned cause. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED MAR 1 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6795
STATE FILE NUMBER
662
Registrar's No.

Registration District No. 318 Primary Registration District No. 1003

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) Mo St. Louis b. COUNTY <i>St. Louis</i>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY - OR TOWN Vinita Park		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>04</i> BARNES HOSPITAL			Length of stay in 1b 1 da		d. STREET ADDRESS (If outside, give location) 8383 Midland.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last EDGAR EDWARD ZOLL			4. DATE OF DEATH Month Day Year JAN. 21, 1957				
5. SEX Male <input checked="" type="checkbox"/>	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 7 1889		9. AGE (In years last birthday) 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Grocer		10b. KIND OF BUSINESS OR INDUSTRY Retail		11. BIRTHPLACE (City and state or country) Quincy Ill		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Zoll				14. MOTHER'S MAIDEN NAME Minnie Altemeyer			
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. 490-01-2535		17. INFORMANT Address Mamie Zoll Vivita Park Mo			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia Tracheal Aspiration Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Cerebral Vascular Accident DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Emphysema (chronic far advanced)							INTERVAL BETWEEN ONSET AND DEATH 48 hrs. 6 mos.
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.)				
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 COUNTY STATE			
21. I attended the deceased from JAN. 20, 1957, to JAN. 21, 1957 and last saw her alive on JAN. 21, 1957 Death occurred at 1:30 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <i>Dr. V. S. ...</i> M.D.				22b. ADDRESS BARNES HOSPITAL		22c. DATE SIGNED 1/21/57	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1/24/57	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis Mo		
24. FUNERAL DIRECTOR Ortmann F Home 9222 Lackland Overland Mo				25. DATE RECD. BY LOCAL REG. JAN 22 '57		26. REGISTRAR'S SIGNATURE <i>J. Carl Smith M.D.</i>	

STATE OF
MISSISSIPPI
DEPARTMENT OF HEALTH

White Male
Retired Grocer
Henry Wolf
Listed
Cotton III
USA
General Attorneys

100-01-1000-10-004

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 *Al C Ostermann*

Licensed Embalmer No. *34*

P. O. Address

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.

MISSISSIPPI
DEPARTMENT OF HEALTH