

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

12694

State File No.

FILED APR 29 1957

BIRTH NO. _____ REG. DIST. NO. 116 PRIMARY REG. DIST. NO. 3020 Registrar's No. 126

1. PLACE OF DEATH a. COUNTY <u>FRANKLIN</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>PULASKI</u>	
b. CITY OR TOWN <u>WARRINGTON, Mo.</u>	c. LENGTH OF STAY (In this place) <u>7 Day</u>	c. CITY OR TOWN <u>DIXON</u>	d. Is Residence within limits of a city incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ST. FRANCIS HOSP.</u>		e. STREET ADDRESS (If rural, give location) <u>0950</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>LAURA</u> b. (Middle) <u>A.</u> c. (Last) <u>ZIMMER</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>APR. 23, 1957</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>Aug 27, 1882</u>	9. AGE (In years last birthday) <u>74</u>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and State or Foreign Country) <u>MADISON COUNTY, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>

13a. FATHER'S NAME <u>James J. Quinten</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Miller</u>	14. NAME OF HUSBAND OR WIFE <u>DECEASED</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>Mr. Myrtle Smith</u> ADDRESS <u>8540 Council Bluffs Pine Lawn, Mo.</u>

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>UREMIA</u>		<u>10 Days</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>CHRONIC PYELONEPHRITIS</u>		<u>YEARS</u>
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>HYPERTENSION</u>		<u>YEARS</u>

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION <u>6000</u>	20. AUTOPSY? <u>2</u> 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 APRIL 7, 1957 to APRIL 23, 1957, that I last saw the deceased alive on APRIL 22, 1957, and that death occurred at 12:00 A.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Robert Crawford M.D.</u>	23b. ADDRESS <u>Shelburn, Mo.</u>	23c. DATE SIGNED <u>Apr. 23, 1957</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	24b. DATE <u>APR. 25, 1957</u>	24c. NAME OF CEMETERY OR CREMATORY <u>CALHOUN</u>
24d. LOCATION (City, town, or county) (State) <u>ST. LOUIS, MO.</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>R. Cady Crystal City, Mo.</u>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>Apr. 23, 1957</u> <u>H. Hedmann</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>R. Cady Crystal City, Mo.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

99-0

DEF.

MAY 1 1957

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 *Lester A Witt*

Licensed Embalmer No. *325*
P. O. Address *Washington*

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.