

Health,  
, & Welfare  
S. Public  
th Service

FILED DEC 11 1957

STANDARD CERTIFICATE OF DEATH

406886  
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5540

S. 300  
v. 1-57

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>INDEPENDENCE, MO</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VA HOSPITAL</b>			Length of stay in 1b <b>1 day</b>		d. STREET ADDRESS (If outside, give location) <b>3008 S. CHRYSLER</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>SEVRIN ALOIS ZELLNER</b>				4. DATE OF DEATH Month Day Year <b>November 19, 1957</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>February 28, 1917</b>		9. AGE (In years last birthday) <b>40</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Glass Cutter</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>K.C.M.O. POSTLE WAIT Glass Co.</b>		11. BIRTHPLACE (City and state or country) <b>Kansas City, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Ben Zellner</b>			13b. MOTHER'S MAIDEN NAME <b>Louise Barr</b>			14. NAME OF HUSBAND OR WIFE <b>Dorothy Zellner</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WWII</b>			16. SOCIAL SECURITY NO. <b>496 10 6748</b>		17. INFORMANT Address <b>Records</b> <b>VA Hospital, Kansas City, Mo. Official</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia, bilateral; severe, bilateral pulmonary congestion and edema</b> DUE TO (b) _____ DUE TO (c) <b>Ulcerated bronchogenic carcinoma involving carnia, right main stem bronchus and right lung</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (List in order of importance, and list them in PART I (a)) <b>Right main stem bronchus and right lung</b>							INTERVAL BETWEEN ONSET AND DEATH	
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 <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 <b>November 18, 1957</b> to <b>November 19, 1957</b> and last saw him <b>drive on</b> Death occurred at <b>3:25 PM</b> on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <b>W. J. Williams, M.D.</b> (Degree or title) <b>D</b>				22b. ADDRESS <b>VA Hospital, Kansas City, Mo.</b>		22c. DATE SIGNED <b>11/20/57</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>Nov. 22, 1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>BLUE SPRING'S CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>BLUE SPRINGS Missouri</b>			
24. FUNERAL DIRECTOR ADDRESS <b>DW. NEWCOMB'S SONS 1331 BRUSH CREEK KANSAS CITY, MO.</b>			25. DATE RECD. BY LOCAL REG. <b>11-22-57</b>		26. REGISTRAR'S SIGNATURE <b>Irlva Marshall</b>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

(Licensed Embalmer's Statement on Reverse Side)

