

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-013371

STATE FILE NUMBER

FILED MAY 5 1958

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 448

300

-57

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) St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Joseph
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph's Hosp.		Length of stay in 1b Life	d. STREET ADDRESS (If outside, give location) R. F. D. #7
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First MIDDLE Last BERTHA LOUISE ZIMMER			4. DATE OF DEATH Month Day Year April 24 1958			
--	--	--	---	--	--	--

5. SEX Female	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. 5, 1873	9. AGE (In years next birthday) 84	10. FUNDING YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
------------------	---------------------------	---	-----------------------------------	---------------------------------------	--	----------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) St. Joseph Missouri	12. CITIZEN OF WHAT COUNTRY? USA
--	---	---	-------------------------------------

13a. FATHER'S NAME John Miller	13b. MOTHER'S MAIDEN NAME Elizabeth Speidel	14. NAME OF HUSBAND OR WIFE John L. Zimmer (Deceased)
-----------------------------------	--	--

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. None	17. INFORMANT Mr. John L. Zimmer	Address R. F. D. #7 St. Joseph, 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) <u>VENTRICULAR FIBRILLATION</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 HR.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>HYPERACTIVE MYOCARDIUM</u>	<u>3 MOS.</u>
	DUE TO (c) <u>4331</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>SENILITY</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)
---	--

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 1/29/57 to 4/24/58 and last saw him alive on 4/24/58.
Death occurred at 9:40A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>John I. Rogers M.D.</u>	(Degree or title) <u>0</u>	22b. ADDRESS <u>307 Kirkpatrick Bldg. St. Joseph, Mo.</u>	22c. DATE SIGNED <u>4/25/58</u>
--	----------------------------	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4-26-58	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	23d. LOCATION (City, town, or county) (State) St. Joseph Missouri
---	----------------------	--	--

24. FUNERAL DIRECTOR <u>Stammy Funeral Home</u>	ADDRESS <u>St. Joseph, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>April 25, 1958</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Clark Woodell</u>
--	-----------------------------------	---	--

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Charles E. Bennett*

Licensed Embalmer No. *4677*
P. O. Address *St. Joseph mo*

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.