

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-029619

STATE FILE NUMBER

FILED AUG 19 1958 Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 198

S. 300

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542

1. PLACE OF DEATH a. COUNTY <b>Livingston</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Livingston</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Chillicothe</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Chillicothe</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>316 Henry St.</b>			Length of stay in lb <b>10 yrs.</b>		d. STREET ADDRESS (If outside, give location) <b>316 Henry St.</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>CECIL</b> Last <b>ZORNES</b>				4. DATE OF DEATH Month <b>August</b> Day <b>13</b> Year <b>1958</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>18 Feb. 1890</b>		9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) Months Days Hours Min. <b>68</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>		11. BIRTHPLACE (City and state or country) <b>Jamison, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13a. FATHER'S NAME <b>John Zornes</b>			13b. MOTHER'S MAIDEN NAME <b>Unknown</b>			14. NAME OF HUSBAND OR WIFE <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no, and when) (If yes, give war or dates of service) <b>Unknown</b>			16. SOCIAL SECURITY NO. <b>488-14-2788</b>		17. INFORMANT Address <b>Mrs. John Curtis: Bethany, Missouri</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>Coronary Occlusion</b>							INTERVAL BETWEEN ONSET AND DEATH <b>Instantly</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____									
DUE TO (c) _____							4201		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)							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.)						
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 _____ to _____ and _____ alive on _____ Death occurred at <b>5 P.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <b>Joseph Conrad M.D. (CORNER)</b>			22b. ADDRESS <b>Chillicothe, Mo</b>			22c. DATE SIGNED <b>Aug 14 '58</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>Aug. 14, '58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>UNKNOWN</b>		23d. LOCATION (City, town, or county) (State) <b>Kansas City, Missouri</b>				
24. FUNERAL DIRECTOR ADDRESS <b>NORMAN FN'L HOME: Chillicothe, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>Aug. 14, '58</b>		26. REGISTRAR'S SIGNATURE <b>Frances B Neill</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.

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 *Elton G. Norman* .....

Licensed Embalmer No...4036.....  
P. O. Address Chillicothe, Ms.....

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.