THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-000382
STATE FILE NUMBER

FILED JAN 12 1959 Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 2

1. PLACE OF DEATH
a. COUNTY Buchanan
b. CITY OR TOWN St Joseph — Inside Limits Yes [X] No [ ]
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1806 N. 22nd St. — Length of stay in lb 3 mos

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo b. COUNTY HOLT
c. CITY OR TOWN Maitalnd 0440 — Inside Limits Yes [ ] No [X]
d. STREET ADDRESS (If outside, give location) — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First Lula Middle C. Last Zeller

4. DATE OF DEATH: Month Jan. Day 2nd. Year 1959

5. SEX male
6. COLOR OR RACE white
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH 6 24 1870
9. AGE (In years last birthday) 88 yrs — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife
10b. KIND OF BUSINESS OR INDUSTRY home-own
11. BIRTHPLACE (City and state or country) Savannah, Mo
12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME James B Peters
13b. MOTHER'S MAIDEN NAME Ann America Culp
14. NAME OF HUSBAND OR WIFE Wilbert S Zeller
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. none
17. INFORMANT Address Mrs Lora Welch, St Joseph, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage. — INTERVAL BETWEEN ONSET AND DEATH 7 hours.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Arterio-sclerosis. — years.
DUE TO (c) Hypertension. — years.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 33/X
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
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 Sept. 29 1958, to Dec. 18, 1958 and last saw her alive on Dec. 18, 1958
Death occurred at Approx. 11:55 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) William R. Titcomb, D.O.
22b. ADDRESS 1105 N. 26th. St. Joseph, Mo.
22c. DATE SIGNED Jan. 2, 1959

23a. BURIAL, CREMATION, REMOVAL (Specify) burial
23b. DATE 1/4/1959
23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery
23d. LOCATION (City, town, or county) Skidmore (State) Mo.

24. FUNERAL DIRECTOR ADDRESS D M Atkinson Maryville
25. DATE RECD. BY LOCAL REG. Jan 5 1959
26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell
(License Embalmer's Statement on Reverse Side)

Dr. Wm. R. Titcomb
Use ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
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 G. M. Ateheson

Licensed Embalmer No. 2379

P. O. Address Maxwell

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.