

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-007824
STATE FILE NUMBER
1825

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

FILED MAR 10 1959

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo.</i> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Louis</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>St. Louis</i> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>4240 GERTRUDE</i>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) <i>4240 GERTRUDE</i> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>ANTON</i> Middle Last <i>ZAHARIA</i>			4. DATE OF DEATH Month <i>FEB</i> Day <i>18</i> Year <i>1959</i>
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 8, 1896</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>BEER BOTTLER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>BUSCH</i>	9. AGE (In years last birthday) <i>62</i> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (City and state or country) <i>HUNGARY</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13a. FATHER'S NAME <i>ANTON ZAHARIA</i>		13b. MOTHER'S MAIDEN NAME <i>NOT KNOWN</i>	14. NAME OF HUSBAND OR WIFE <i>LYDIA</i>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, specify unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>489-01-4607</i>	17. INFORMANT Address <i>LYDIA ZAHARIA 4240 GERTRUDE</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Adenocarcinoma left lung</i>			INTERVAL BETWEEN ONSET AND DEATH <i>3 months</i>
Conditions, if any, which gave rise to above cause (a), starting the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			<i>163X</i>
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 _____ 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 <i>Dec. 5, 1958</i> to <i>February 18, 1959</i> and last saw him alive on <i>February 12, 1959</i> Death occurred at <i>7</i> <i>at</i> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Bernard T. Koan M.D.</i>		22b. ADDRESS <i>4268 Delo Street, St. Louis 16, Mo.</i>	22c. DATE SIGNED <i>2/18/59</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>CREMATION</i>	23b. DATE <i>2/21/1959</i>	23c. NAME OF CEMETERY OR CREMATORY <i>VALHALLA CREMATORY</i>	23d. LOCATION (City, town, or country) (State) <i>St. Louis Co., Mo.</i>
24. FUNERAL DIRECTOR <i>J L ZIEGENHEIN & SONS 7027 GRAVOIS</i>		25. DATE RECD. BY LOCAL REG. <i>FEB 20 '59</i>	26. REGISTRAR'S SIGNATURE <i>Koan Smith M.D.</i>

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *E. P. Kidwell*

Licensed Embalmer No. *3877*
P. O. Address *7027 Hawaii*

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.