Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-016966
STATE FILE NUMBER

FILED MAY 26 1959 Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 144

1. PLACE OF DEATH
a. COUNTY Callaway
b. CITY OR TOWN Fulton — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) St. Hospital #1 — Length of stay in Ib 3 months

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Pettis
c. CITY OR TOWN Sedalia — Inside Limits Yes [X] No [ ]
STREET ADDRESS (If outside, give location) 26th and Washington — Reside on Farm Yes [ ] No [✓]

3. NAME OF DECEASED (Type or print) First Oliver Middle Last Zeller
4. DATE OF DEATH Month May Day 20 Year 1959
5. SEX Male
6. COLOR OR RACE White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH May 22 1876
9. AGE (In years last birthday) 82 — IF UNDER 1 YEAR Months 11 Days 28 — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal miner and Livestock Dealer
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) Illinois
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Henry Zeller
13b. MOTHER'S MAIDEN NAME Elizabeth Hen
14. NAME OF HUSBAND OR WIFE Nellie Zeller
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or Unknown) Unknown (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. Unknown
17. INFORMANT Address St. Hospital No. 1, Fulton, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Pulmonary Edema
DUE TO (c) Cardiac Decompensation

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
Chronic Brain Syndrome with Cerebral Arteriosclerosis 4344

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 Feb 13, 1959, to May 20, 1959 and last saw her/him alive on May 20, 1959
St. Hosp.
Death occurred at 2:50 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) James K. Cutterbuck M.D.
22b. ADDRESS St. Hospital No. 1
22c. DATE SIGNED 5-20-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE May 20-1959
23c. NAME OF CEMETERY OR CREMATORY
23d. LOCATION (City, town, or county) Sedalia (State) Mo

24. FUNERAL DIRECTOR Ewing Funeral Home ADDRESS Sedalia, Mo.
25. DATE RECD. BY LOCAL REG. May 20-1959
26. REGISTRAR'S SIGNATURE Maretta Lawrence

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

MAY 27 1959

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 Ralph E. Baker

Licensed Embalmer No. 2419

P. O. Address Sykesville, Md.

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.