

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-024476

FILED VS JUL 20 1959

STATE FILE NUMBER

Registration District No. 70 Primary Registration District No. _____ Registrar's No. 35

DED

1. PLACE OF DEATH a. COUNTY <u>Black</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Black</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kahoka</u>		c. CITY OR TOWN <u>Kahoka</u>	
Length of stay in 1b <u>2 Days</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Mitchell Nursing H</u>		d. STREET ADDRESS (If outside, give location) <u>W. Thompson St</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>P.</u> Last <u>Zimmerman</u>			4. DATE OF DEATH Month <u>7</u> Day <u>12</u> Year <u>1959</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W.</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10-23-1959</u>
9. AGE (last birthday) <u>99</u>		IF UNDER 1 YEAR: months _____ Days _____	
IF UNDER 24 HR: Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>✓</u>	
11. BIRTHPLACE (City and state or country) <u>near Kahoka Black Co. Mo. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Jacob Blum</u>		13b. MOTHER'S MAIDEN NAME <u>Katherine Wiegner</u>	
14. NAME OF HUSBAND OR WIFE <u>George M. Zimmerman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>✓</u>	
17. INFORMANT <u>Mrs. Ruth</u>		Address <u>505 W. Thompson St Kahoka Mo.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Mremia</u>			<u>days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis</u>			<u>hrs</u>
DUE TO (c) <u>Arteriosclerosis</u>			<u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days.
			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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. Month, Day, Year _____			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 <u>5-31-59</u> to <u>7-12-59</u> and last saw her alive on <u>7-12-59</u>			
Death occurred at <u>10:55 P</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Robert L. Willis</u>		22b. ADDRESS <u>Kahoka Mo.</u>	22c. DATE SIGNED <u>7-12-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremial</u>	23b. DATE <u>7-15-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St Paul Cemetery</u>	23d. LOCATION (City, town, or county) <u>near Kahoka Mo. Black Co.</u>
24. FUNERAL DIRECTOR <u>Fred J. Karle</u>	ADDRESS <u>Kahoka Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>7/18-59</u>	26. REGISTRAR'S SIGNATURE <u>J.P. Brindley</u>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Fred J Karle

Licensed Embalmer No. 1025

P. O. Address Kahoka

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.

