

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-038353

FILED 78 NOV 16 1959

Registration District No. 317 Primary Registration District No. 544 Registrar's No. 2905 STATE FILE NUMBER

ENDED

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <u>ST LOUIS</u>		b. CITY (If outside corporate limits, give TOWNSHIP only) <u>KIRKWOOD</u>		a. STATE <u>MO</u>		b. COUNTY <u>ST LOUIS</u>	
Length of stay in 1b <u>2 DAYS</u>		c. CITY OR TOWN <u>ROCK HILL</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST JOSEPH'S HOSPITAL</u>				d. STREET ADDRESS (If outside, give location) <u>925 LEONARD DRIVE</u>			
3. NAME OF DECEASED				4. DATE OF DEATH			
First <u>OTHELIA</u>		Middle <u>KOCHLER</u>		Last <u>ZURWESTE</u>		Month Day Year <u>11 1 1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6-27-1894</u>	9. AGE (last birthday) <u>65</u>	IF UNDER 1 YEAR Months <u>4</u> Days <u>4</u>	IF UNDER 24 HR Hours <u>4</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WAITRESS</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HI SCHOOL CAFETERIA</u>		11. BIRTHPLACE (City and state or country) <u>ST LOUIS CO MO</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>LEONARD KOCHLER</u>			13b. MOTHER'S MAIDEN NAME <u>BERTHA GAYER</u>		14. NAME OF HUSBAND OR WIFE <u>GEORGE S ZURWESTE</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>E. S. ZURWESTE 925 Leonard Dr R.N. 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>Cerebral Hemorrhage</u>						<u>2 days</u>	
DUE TO (b) <u>Arteriosclerotic Heart Disease</u>						<u>2 mos.</u>	
DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Diabetes Mellitus 10 years</u>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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.) <u>None</u>			
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____	Month, Day, Year <u>-----</u>						
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.) <u>None</u>		20f. CITY, TOWN, OR LOCATION <u>ST LOUIS CO</u>		STATE <u>MO</u>	
21. I attended the deceased from <u>1931</u> to <u>11-1-59</u> and last saw him/her alive on <u>11-1-59</u> Death occurred at <u>1145 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Charles C. Grace M.D.</u>				22b. ADDRESS <u>19 E. Lockwood Ave., Webster Groves 19, Mo.</u>		22c. DATE SIGNED <u>11-2-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>11-4-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LAKE CHARLES CEMETERY</u>		23d. LOCATION (City, town, or county) <u>ST LOUIS CO</u>		(State) <u>MO</u>	
24. FUNERAL DIRECTOR <u>MITTELBERG</u>		ADDRESS <u>WEBSTER GROVES MO</u>		25. DATE RECD. BY LOCAL REG. <u>11-2-59</u>		26. REGISTRAR'S SIGNATURE <u>John C. ...</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 Robert M Murray

Licensed Embalmer No. 3749

P. O. Address St Louis

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.