

FEDERAL BUREAU OF INVESTIGATION - STANDARD CERTIFICATE OF DEATH
FILED VS JAN 11 1960

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Registration District No. _____ Primary Registration District No. _____ Registrar's No. **211471** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		c. CITY OR TOWN Riverview	
c. FULL NAME OF (If not in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		d. STREET ADDRESS (If outside, give location) 236 Perthshire	

3. NAME OF DECEASED (Type or print) First Middle Last MARY JOHANNA ZOLLE			4. DATE OF DEATH Month Day Year DECEMBER 10, 1959		
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9-29-1891	9. AGE (last birthday) 68	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk (Retired) Sears Roebuck & Co.		10b. KIND OF BUSINESS OR INDUSTRY Chicago, Ill.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Unknown Adolph		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Late Roy A. Zolle	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 495-26-6066a		17. INFORMANT Address Roy E. Zolle 5250 Parker Ave.	

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) HEMORRHAGE, VAGINAL			2 DAYS
DUE TO (b) RADIATION NECROSIS			2 WEEKS
DUE TO (c) EPIDERMOID CARCINOMA OF CERVIX <i>171x</i>			5 YEARS
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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 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 **NOV. 5, 1959** to **DEC. 10, 1959** and last saw her/him alive on **DEC. 10, 1959**
 Death occurred at **9:45 A.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>C. O. Miller, M.D.</i>	22b. ADDRESS BARNES HOSPITAL	22c. DATE SIGNED 12/11/59
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 12-14-1959	23c. NAME OF CEMETERY OR CREMATORY Sunset Burial Park
23d. LOCATION (City, town, or county) St. Louis Co., Mo.		24. FUNERAL DIRECTOR ADDRESS Kriegshauser 4228 S. Kingshighway
25. DATE RECD. BY LOCAL REG. DEC 11 1959		26. REGISTRAR'S SIGNATURE <i>Ronald Smith, M.D.</i>

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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed R. W. Stoveland

Licensed Embalmer No. 4007

P. O. Address _____

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.