

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-031113

FILED VS AUG 19 1960

160

Registration District No. 5592

Primary Registration District No. 98

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <b>Jefferson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY _____	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Rural Joachim Twp.</b>		Length of stay in lb <b>3 months</b>	c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. View Convalescent Home</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>2006 Blendon Place</b> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Carrie</b> (Caroline) Middle _____ Last <b>Zoeller</b>			4. DATE OF DEATH Month <b>Aug.</b> Day <b>6</b> , Year <b>1960</b>		
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5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>5/28/1874</b>	9. AGE (last birthday) <b>86</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	11. BIRTHPLACE (City and state or country) <b>Illinois</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
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13a. FATHER'S NAME <b>Mortz Kempf</b>	13b. MOTHER'S MAIDEN NAME <b>Bertha Gruner</b>	14. NAME OF HUSBAND OR WIFE <b>John L. Zoeller</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Henry Hoffmann</b> Address <b>4022 Wyo., St. Louis, Mo.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Cerebral Hemorrhage.</b>		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
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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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year
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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 <b>Crystal City, Mo.</b> COUNTY _____ STATE _____
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21. I attended the deceased from **4-25-60** to **8-6-60** and last saw her alive on **8-6-60**  
Death occurred at **2:45 P.M.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>B. D. Annell, M.D.</b>	22b. ADDRESS <b>Crystal City, Mo.</b>	22c. DATE SIGNED <b>8-8-60</b>
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23a. REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>Aug. 9, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>New St. Marcus</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>
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24. FUNERAL DIRECTOR <b>Albert H. Hoppe</b> ADDRESS <b>4700 Washington Blvd.</b>	25. DATE RECD. BY LOCAL REG. <b>8-8-60</b>	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

AUG 19 1960

JAN 18 1965

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 Donald W. Winger

Licensed Embalmer No. 4602

P. O. Address Felton, Pa.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.