

# FEDERAL BUREAU OF INVESTIGATION

## FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-045434

FILED VS JAN 4 1961  
 Registration District No. 70

Primary Registration District No. \_\_\_\_\_ Registrar's No. 56

STATE FILE NUMBER

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Clark County, Mo.</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clark City, Mo.</u> Length of stay in 1b _____ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION _____ Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Clark</u> c. CITY OR TOWN <u>Clark City, Mo.</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) _____ Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>MARY KATHRYN ZINNERT</u>			<b>4. DATE OF DEATH</b> Month Day Year <u>12/22/60</u>			
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>4/11/1917</u>	<b>9. AGE (last birthday)</b> <u>43</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HR Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> _____		<b>11. BIRTHPLACE</b> (City and state or country) <u>Pittsfield, Illinois</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>USA</u>
<b>13a. FATHER'S NAME</b> <u>William Hassett</u>		<b>13b. MOTHER'S MAIDEN NAME</b> <u>Iellie Rhodes, Hassett</u>		<b>14. NAME OF HUSBAND OR WIFE</b> <u>Emmet Zinnert</u>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <u>341-16-8013</u>	<b>17. INFORMANT</b> Address <u>Emmet Zinnert, Clark City, Mo.</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO (b) <u>arteriosclerotic Heart Disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>15 min.</u> <u>14 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Congestive Heart Failure</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	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.) _____			
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____	<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE _____	
<b>21. I attended the deceased from</b> <u>Sept 1, 1960</u> to <u>Dec 22, 1960</u> and last saw her <sup>her</sup> alive on <u>Dec 22, 1960</u> Death occurred at <u>2:40 P.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.						
<b>22a. SIGNATURE</b> (Degree or title) <u>Cecil L. Watson M.D.</u>			<b>22b. ADDRESS</b> <u>Kahoka Mo.</u>		<b>22c. DATE SIGNED</b> <u>12-22-60</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>	<b>23b. DATE</b> <u>12/24/60</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Kahoka City Crematory</u>		<b>23d. LOCATION</b> (City, town, or county) (State) <u>Kahoka, Missouri</u>		
<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>Delbert L. Shaffer, Kahoka, Mo.</u>		<b>25. DATE RECD. BY LOCAL REG.</b> <u>12-28-60</u> <u>12-28-60</u>		<b>26. REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>		

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1967 I 1200P

### 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 Delbert Sheffer

Licensed Embalmer No. 5063

P. O. Address Kohaka, MO

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.