

AMENDED

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 1 week	c. CITY OR TOWN St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Jewish Hospital		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 4946 Claxton A venue
			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last Edgar Zollman			4. DATE OF DEATH Month Day Year January 27 1961		
5. SEX Male	6. COLOR OR RACE white	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 5-2-1915	9. AGE (last birthday) 45	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder		10b. KIND OF BUSINESS OR INDUSTRY McDonnell Air Craft	11. BIRTHPLACE (City and state or country) Kendallville, Indiana	12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Edgar J. Zollman		13b. MOTHER'S MAIDEN NAME Cora Hayes		14. NAME OF HUSBAND OR WIFE Melba Zollman	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes 2nd World War	16. SOCIAL SECURITY NO.	17. INFORMANT Address Mrs. Melba Zollman, 4946 Claxton Ave
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)		about 1 1/2 hr
DUE TO (b) <i>Rupture of cerebral aneurysm</i>		
DUE TO (c) <i>(Previous small rupture of aneurysm on 1/21/61)</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		

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 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
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21. I attended the deceased from <u>1/17/60</u> to <u>1/27/61</u> and last saw him alive on <u>1/27/61</u> Death occurred at <u>6:40 pm</u> on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>Joseph B. Kendrick</i>	22b. ADDRESS <i>462 N. Taylor Ave St. Louis 8 Mo</i>	22c. DATE SIGNED <u>1/30/61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Jan. 31, 1961	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri
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24. FUNERAL DIRECTOR Math Hermann & Son, Inc., 2161 E. Fair St. Louis, 7, Missouri	25. DATE RECD. BY LOCAL REG. JAN 30 1961	26. REGISTRAR'S SIGNATURE <i>Stan Smith, M.D.</i>
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

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 Clement M. Neary

Licensed Embalmer No. 3732

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.