

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-012202

AMENDED

Registration District No. 317 Primary Registration District No. 500 590 Registrar's No. 713 STATE FILE NUMBER

FILED MAR 27 1961

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Florissant</u>		Length of stay in lb <u>40 yrs.</u>	c. CITY OR TOWN <u>Florissant</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>6 Claire Drive</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>370 St. Denis St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>HENRY</u> Last <u>ZOELLER</u>	4. DATE OF DEATH Month <u>March</u> Day <u>14</u> Year <u>1961</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3-9-1880</u>	9. AGE (last birthday) <u>81</u>	IF UNDER 1 YEAR Months Days Hours Min.	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) <u>Blacksmith</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Blacksmithing</u>	11. BIRTHPLACE (City and state or country) <u>Sereno, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>John Zoeller</u>	13b. MOTHER'S MAIDEN NAME <u>Louise Pierich</u>	14. NAME OF HUSBAND OR WIFE <u>Deceased</u>
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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) <u>No</u>	17. INFORMANT Address <u>Teresa Weidinger, 370 St. Denis St. Florissant, Mo.</u>
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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 <u>2-3-59 - 3-14-61</u>
IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u>	DUE TO (b) <u>Arterio Sclerotic Heart Disease</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (c)	

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 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 <u> </u> Month, Day, Year a.m. p.m.	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>7-28-58</u> to <u>3-14-61</u> and last saw him alive on <u>3-13-61</u> Death occurred at <u>3:50</u> <u>A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Robert W. Lahn M.D.</u>	22b. ADDRESS <u>610 N. LAFAYETTE, FLORISSANT</u>	22c. DATE SIGNED <u>3-14-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>3-16-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Boniface Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Perryville, Mo.</u>
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24. FUNERAL DIRECTOR ADDRESS <u>The Florissant Mortuary, Florissant, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>3-14-61</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>
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DATE AMENDED

INSTEAD OF DOCUMENT

SHOULD READ

ITEM NO.

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 *Gene M. Hultebus*

Licensed Embalmer No. 4966

P. O. Address FLORISSANT, 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.