ISSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

RTMENT OF PUBLIC HEALTH AND WELFARE

-61-027536
STATE FILE NUMBER

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6845

FILED AUG 3 1961

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. LOUIS
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: 4318 FRIEDA
Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MO. b. COUNTY
c. CITY OR TOWN: ST. LOUIS
Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 4318 FRIEDA
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First KUNIGUNDE Middle Last ZAHNWEH
4. DATE OF DEATH: Month JULY Day 22 Year 1961
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: OCT. 11. 1882
9. AGE (last birthday): 78
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WORK
10b. KIND OF BUSINESS OR INDUSTRY: AT HOME
11. BIRTHPLACE (City and state or country): GERMANY
12. CITIZEN OF WHAT COUNTRY: U-S-A
13a. FATHER'S NAME: EDWARD ARNETH
13b. MOTHER'S MAIDEN NAME: UNKNOWN
14. NAME OF HUSBAND OR WIFE: ANTON ZAHNWEH
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: WILLIAM ZAHNWEH Address: 6313 DARLOW DR

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Generalized Arteriosclerosis
DUE TO (c): 420.0
INTERVAL BETWEEN ONSET AND DEATH

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. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 3/28/61, to 7/22/61 and last saw her ~~him~~ alive on 7/22/61
Death occurred at 3 A.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Carm Hendin MD
22b. ADDRESS: 4268 Delor
22c. DATE SIGNED: 7/22/61

23a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL
23b. DATE: JULY 24. 1961
23c. NAME OF CEMETERY OR CREMATORY: SUNSET BURIAL PARK
23d. LOCATION (City, town, or county) (State): ST. LOUIS CO. MO
24a. FUNERAL DIRECTOR: Thomas Kutis
ADDRESS: 2906 Gravois
25. DATE RECD. BY LOCAL REG.: JUL 24 1961
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. | SHOULD READ | INSTEAD OF | DATE AMENDED

BY AFFIDAVIT OF DOCUMENT

HENDON

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 Cooley Thompson

Licensed Embalmer No. 4061

P. O. Address Clayton 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.