

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-033880

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 1055

FILED SEP 24 1962

|                                                                                                                                                                                                                                     |                                                                                                           |                                                                                                                                                             |                                                                                                                                                                      |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Buchanan</b>                                                                                                                                                                                      |                                                                                                           | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Kansas</b> b. COUNTY <b>Doniphan</b>                   |                                                                                                                                                                      |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR <b>St. Joseph</b>                                                                                                                                                   |                                                                                                           | c. CITY OR TOWN <b>Troy</b>                                                                                                                                 |                                                                                                                                                                      |
| Length of stay in lb <b>60 Days</b>                                                                                                                                                                                                 |                                                                                                           | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                                                           |                                                                                                                                                                      |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>St. Josephs Hospital</b>                                                                                                                          |                                                                                                           | d. STREET ADDRESS (If outside, give location)<br><b>- - -</b>                                                                                               |                                                                                                                                                                      |
| Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                                                                                                                                                  |                                                                                                           |                                                                                                                                                             |                                                                                                                                                                      |
| 3. NAME OF DECEASED<br>(Type or print) First <b>Nellie</b> Middle <b>Zimmerman</b> Last <b>Zimmerman</b>                                                                                                                            |                                                                                                           | 4. DATE OF DEATH<br>Month <b>Sept.</b> Day <b>16</b> Year <b>1962</b>                                                                                       |                                                                                                                                                                      |
| 5. SEX<br><b>Female</b>                                                                                                                                                                                                             | 6. COLOR OR RACE<br><b>White</b>                                                                          | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>5/27/1887</b>                                                                                                                                 |
| 9. AGE (last birthday)<br><b>75</b>                                                                                                                                                                                                 |                                                                                                           | IF UNDER 1 YEAR IF UNDER 24 HR<br>Months Days Hours Min.                                                                                                    |                                                                                                                                                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Never Worked</b>                                                                                                                  |                                                                                                           | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>                                                                                                            |                                                                                                                                                                      |
| 11. BIRTHPLACE (City and state or country)<br><b>Troy Kansas</b>                                                                                                                                                                    |                                                                                                           | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>                                                                                                                |                                                                                                                                                                      |
| 13a. FATHER'S NAME<br><b>W. F. Zimmerman</b>                                                                                                                                                                                        |                                                                                                           | 13b. MOTHER'S MAIDEN NAME<br><b>Mellie Parker</b>                                                                                                           |                                                                                                                                                                      |
| 14. NAME OF HUSBAND OR WIFE<br><b>Never Married</b>                                                                                                                                                                                 |                                                                                                           |                                                                                                                                                             |                                                                                                                                                                      |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>                                                                                                            |                                                                                                           | 16. SOCIAL SECURITY NO.<br><b>None</b>                                                                                                                      |                                                                                                                                                                      |
| 17. INFORMANT<br><b>Russel Hoverson</b>                                                                                                                                                                                             |                                                                                                           | Address<br><b>Troy Kansas</b>                                                                                                                               |                                                                                                                                                                      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of Breast</b>                                                                          |                                                                                                           |                                                                                                                                                             | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 1/2</b>                                                                                                                     |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) _____<br>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.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input 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.)                                                                |                                                                                                                                                                      |
| 20c. TIME OF INJURY<br>Hour _____ a.m. _____ p.m.<br>Month, Day, Year _____                                                                                                                                                         |                                                                                                           |                                                                                                                                                             |                                                                                                                                                                      |
| 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                                                                                                                                                         |
| 21. I attended the deceased from <b>1959</b> , to <b>9-16-62</b> and last saw her <b>mm</b> alive on <b>9-16-62</b><br>Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated. |                                                                                                           |                                                                                                                                                             |                                                                                                                                                                      |
| 22a. SIGNATURE<br><b>Clement C. Zimmerman</b> (Degree or title)                                                                                                                                                                     |                                                                                                           | 22b. ADDRESS<br><b>St. Joseph Mo</b>                                                                                                                        | 22c. DATE SIGNED<br><b>9-19-62</b>                                                                                                                                   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>                                                                                                                                                                         | 23b. DATE<br><b>9/16/62</b>                                                                               | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olive</b>                                                                                                      | 23d. LOCATION (City, town, or county) (State)<br><b>Troy Kansas</b>                                                                                                  |
| 24. FUNERAL DIRECTOR<br><b>Vernon B. Lillietto</b> ADDRESS<br><b>Troy Kansas</b>                                                                                                                                                    |                                                                                                           | 25. DATE RECD. BY LOCAL REG.<br><b>Sept. 19, 1962</b>                                                                                                       | 26. REGISTRAR'S SIGNATURE<br><b>Wm. Clark Hardell</b>                                                                                                                |

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

C.L. DuMont Medical Certification

VS 300  
Rev. 4/59

15117

28150

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9170X

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123-0

131-0

SEP 26 1962

Permit requested 9/16/62

# 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 Charles E. Bennett

Licensed Embalmer No. 4677

P. O. Address St. Joseph 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.