

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-001955-

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 171

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

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DOCUMENT

MEDICAL CERTIFICATION
BY AFFIDAVIT OF
C. G. Lettich

USE BLACK INK OR TYPEWRITER RIBBON

| | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|
| FILED JAN 28 1963 | | 1. PLACE OF DEATH a. COUNTY <u>Jackson</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u> | | Length of stay in 1b <u>73 yrs.</u> | | c. CITY OR TOWN <u>Kansas City</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>Roanoke Nursing Home</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (if outside, give location) <u>3660 Summit</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>MINNIE A. ZORN</u> | | | 4. DATE OF DEATH Month Day Year <u>January 7, 1963</u> | | |
| 5. SEX <u>Female</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>4-3-1873</u> | 9. AGE (last birthday) <u>89</u> | IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | | 11. BIRTHPLACE (City and state or country) <u>Streater, Illinois</u> | |
| 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | | 13a. FATHER'S NAME <u>Lucian Reynolds</u> | | 13b. MOTHER'S MAIDEN NAME <u>Barbara Spellman</u> | |
| 14. NAME OF HUSBAND OR WIFE <u>Charles H. Zorn</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>[REDACTED]</u> | |
| 17. INFORMANT <u>Miss Charlotte I. Zorn</u> | | Address <u>3912 Warwick</u> | | 18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ 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 | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 Hour a.m. p.m. _____ Month, Day, Year _____ | | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 <u>2/8/42</u> to <u>1/7/63</u> and last saw her <u>4p.</u> alive on <u>1/7/63</u> . Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE <u>[Signature]</u> | | (Degree or title) _____ | | 22b. ADDRESS <u>805 1/2 15 Blueprints Ln</u> | |
| 22c. DATE SIGNED <u>1/8/63</u> | | (State) <u>[State]</u> | | 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | |
| 23b. DATE <u>1-10-63</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Washington Cemetery</u> | | 23d. LOCATION (City, town, or county) <u>Kansas City, Missouri</u> | |
| 24. FUNERAL DIRECTOR <u>Melody-McGilley-Eylar</u> | | ADDRESS <u>20 W. Linwood</u> | | 25. DATE RECD. BY LOCAL REG. <u>1-10-63</u> | |
| 26. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | | | |

Mr. C. J. Litch
1508 S. 15th Ave. Spring
Cal. 5-11-7

Please Call Melby-Melby
at PL 3-6200 when Dr.
Litch has signed

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 Hayd P. Dickson

Licensed Embalmer No. 5120

P. O. Address K. C. 4, 1700

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.