

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-030688

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **8116** STATE FILE NUMBER

DO NOT WRITE ON THIS STUB AMENDED

VS 300
Rev. 4/59

1
2 **213**
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4 **0**
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.		Length of stay in 1b 294 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE No. b. COUNTY		c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>									
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis Chronic				- Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 5800 ARSENAL ST				Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last Clement Zander			4. DATE OF DEATH Month Day Year 8 8 1963			5. SEX Male		6. COLOR OR RACE White		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 1-31-81		9. AGE (last birthday) 82		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) PRINTING PRESSMAN BERNARD CO				10b. KIND OF BUSINESS OR INDUSTRY Missouri				11. BIRTHPLACE (City and state or country) U-S-A				12. CITIZEN OF WHAT COUNTRY							
13a. FATHER'S NAME Henry ZANDER				13b. MOTHER'S MAIDEN NAME CATHERINE KUHNER				14. NAME OF HUSBAND OR WIFE HELEN ZANDER				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) NO				17. INFORMANT Address HELEN BENDER 4741 VALMEYER			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Lobar Pneumonia												INTERVAL BETWEEN ONSET AND DEATH 24 hrs.							
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) 490X																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) Arteriosclerotic Heart Disease - 9mo.										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 <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 Hour a.m. p.m. 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 10-18-62 to 8-8-63 and last saw her alive on 8-8-63 Death occurred at 3:00 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.																			
22a. SIGNATURE (Degree or title) John W. Beckham M.D.						22b. ADDRESS 5800 Arsenal			22c. DATE SIGNED 8/9/63										
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE AUG. 10, 1963		23c. NAME OF CEMETERY OR CREMATORY ST. PETER & PAUL CEM.		23d. LOCATION (City, town, or county) ST. LOUIS		23e. STATE MO.											
24. FUNERAL DIRECTOR Thomas Kutis 2906 Gravois				25. DATE RECD. BY LOCAL REG. AUG 9 1963		26. REGISTRAR'S SIGNATURE Geard Smith. M.D.													

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

Eleana Province

Licensed Embalmer No.

3403

P. O. Address

2906 Gravois

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.