APR 28 1930

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

8459

1. PLACE OF DEATH
County Henry — Registration District No. 14
Township X — Primary Registration District No. 4211
City Windsor (No. ..... St. ..... Ward) — File No. ..... Registered No. 14

2. FULL NAME Georgia Viola Zehnder

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
F	White	Married

5a. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (OR) WIFE OF Herbert Zehnder

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 23-1896

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
33	2	14	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY) Missouri

PARENTS

10. NAME OF FATHER Joe Warner
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Indiana
12. MAIDEN NAME OF MOTHER Lulie Wilson
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Missouri

14. INFORMANT Mrs. Joe Warner
(Address) Monitor Mo
Filed May 10, 1930 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 9, 1930

17. I HEREBY CERTIFY, That I attended deceased from Jan 26, 1930, to May 9, 1930, that I last saw her alive on May 9, 1930, and that death occurred, on the date stated above, at 4:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Carcinoma of Mediastinum
(duration) 4 yrs 5 mos. ..... ds.
CONTRIBUTORY (SECONDARY) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED? Monitor Mo
IF NOT AT PLACE OF DEATH .....
DID AN OPERATION PRECEDE DEATH? No DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) J. C. McFall M.D.
, 19 (Address) Windsor Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mem Monitor Stones Chapel Mo	5-10-30 19
20. UNDERTAKER Austin Funeral Chapel	ADDRESS Windsor

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.