

**JUN 15 1940**  
Registration District No. **791**

Primary Registration District No. **1003**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

**1. PLACE OF DEATH:**

(a) County \_\_\_\_\_  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Bethesda Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 10 days  
In this community Life  
(Specify whether years, months or days)

8. (a) PRINT FULL NAME Irene Esther Zacharias 267

3. (b) If veteran, name war --- 8. (c) Social Security No. ---

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Walter 6. (c) Age of husband or wife if alive 30 years

7. Birth date of deceased January 27, 1917  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>23</u>	<u>3</u>	<u>18</u>	hr. min.

9. Birthplace St. Louis Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Home Manager

11. Industry or business \_\_\_\_\_

12. Name Joseph Holzinger

13. Birthplace Hungary  
(City, town, or county) (State or foreign country)

14. Maiden name Mary Springer

15. Birthplace Hungary  
(City, town, or county) (State or foreign country)

16. (a) Informant Halle C. Zacharias

(b) Address 3545a Nebraska

17. (a) Burial (b) Date thereof 5/18/40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sunset Burial Park

18. (a) Signature of funeral director Wacker-Walden

(b) Address 2331 S. Broadway

19. (a) MAY 16 1940 (b) \_\_\_\_\_  
(Date received from registrar)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3545a Nebraska  
(If rural, give location)  
(e) If foreign born, how long in U. S. A? \_\_\_\_\_ years.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month May day 14  
year 1940 hour 9 minute 45 p.m.

21. I hereby certify that I attended the deceased from Feb 1940 to May 14 1940  
that I last saw her alive on 5-14-1940 and that death occurred on the date and hour stated above.

Immediate cause of death hemorrhage (uterine)  
12 hr's Post Partum

Due to Placental accreta

Due to 1st

Other conditions full term spontaneous delivery 12 hr's postpartum  
(Include pregnancy within 3 months of death)

Major findings: Ligation of uterine arteries vaginally  
Of operations \_\_\_\_\_  
Of autopsy none

Duration  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_  
(Specify type of place)  
While at work? \_\_\_\_\_ (Specify type of place)  
Means of injury \_\_\_\_\_

23. Signature W.D. Chley (M. D. or other)  
Address 4660 Maryland Date signed 5/15/40

**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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**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 this body is not embalmed, above space should be left blank.**