

S. No. 2
-11-10-39
5-17-39
I X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

20029

State File No. _____

Registrar's No. 4977

Registration District No. _____

Primary Registration District No. _____

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: 937A PARK AV. 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 25 yrs
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County _____
(c) City or town ST. LOUIS 23
(If outside city or town limits write "RURAL")
(d) Street No. 937A PARK AV.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME GEORGE C. ZILM. 45

8. (b) If veteran, name war NO. 3. (c) Social Security No. NONE

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife ELIZABETH ZILM 6. (c) Age of husband or wife if alive 75 years

7. Birth date of deceased: OCTOBER 27 1864
(Month) (Day) (Year)

8: AGE: Years 75 Months 7 Days 10 If less than one day hr. _____ min. _____

9. Birthplace: NEW YORK CITY NEW YORK
(City, town, or county) (State or foreign country)

10. Usual occupation: RETIRED.

11. Industry or business _____

12. Name GUSTAV ZILM

13. Birthplace NEW YORK CITY NEW YORK
(City, town, or county) (State or foreign country)

14. Maiden name ANNA ?

15. Birthplace NEW YORK CITY NEW YORK
(City, town, or county) (State or foreign country)

16. (a) Informant: Elizabeth Zilm

(b) Address: 937A Park Av.

17. (a) BURIAL (b) Date thereof: 6-8-1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: CALVARY CEMETERY

18. (a) Signature of funeral director: E. J. Schmur

(b) Address: 3125 Lafayette Av.

19. (a) JUN 7 1940 (b) _____
(Date of local registration) (Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 6
year 1940 hour 3 minute 30 A. M.

21. I hereby certify that I attended the deceased from 6-1
1940 to 6-6 1940

that I last saw him alive on 6-5 1940
and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral
Apoplexy Duration 5-6 days

Due to Chronic 6-7-40

Due to Chronic 15-7-40

and 15-7-40

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations: _____

Of autopsy: no

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature: [Signature] (M. D. or other) _____

Address: 2844 [Address] Date signed: 6-6-40

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

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

Joseph Bollmer

Licensed Embalmer No. 4014

P. O. Address 3125 Lafayette Ave

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Signature to comply with the above constitutes grounds for revocation of license.)

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