

FILED AUG 28 1941

Registration District No. **791**

Primary Registration District No. **1003**

Registrar's No. **5614**

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:
Alexian Bros. Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **6 hours**
In this community **Life** **0** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Adolph E. Zimmer**

3. (b) If veteran, name war **---** 3. (c) Social Security No. **493-03-5150**

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

6. (b) Name of husband or wife **Catherine** 6. (c) Age of husband or wife if alive **48** years

7. Birth date of deceased **March 23, 1889**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	52	3	13	hr. min.

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

10. Usual occupation **Election Commissioners Office**

11. Industry or business _____

12. Name **Carl Zimmer**

13. Birthplace **Unknown Zimmer**
(City, town, or county) (State or foreign country)

14. Maiden name **Unknown**

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

16. (a) Informant **Catherine Zimmer**

(b) Address **3618a Hartford**

17. (a) **Burial** (b) Date thereof **7/8/41**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Concordia Cemetery**

18. (a) Signature of funeral director **Wacker-Keppler**

(b) Address **3634 Gravois Ave.**

19. (a) **JUL 8 1941** (b) **J. W. Bredenk**
(Date received local registrar) (Registrar's signature)

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. **3618a Hartford St.**
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? **0** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July-** day **5**
year **1941** hour **10** minute **50** p. M.

21. I hereby certify that I attended the deceased from **7/4/41**
to **7/5/41**, 19____ to _____, 19____

that I last saw him alive on _____, 19____ and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Apoplexy**

At Controller's Responsibility

Due to **Cereb**

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

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 **Ernest C. Carter** (M. D. or other) _____

Address **3115 S. Grand** Date signed **7/7/41**

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

179

179

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.