

Registration District No. 773

Primary Registration District No. 6018A

Registrar's No. 158

1. PLACE OF DEATH:  
 (a) County St. Francois  
 (b) City or town Rural St. Francois Twp  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
State Hospital No. 4  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 1 yr. 8 mo. 23 days  
 (Specify whether \_\_\_\_\_)  
 In this community \_\_\_\_\_  
 years, months or days \_\_\_\_\_

3. (a) PRINT FULL NAME HENRY ZINN  
 3. (b) If veteran, name war Unknown  
 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 Iva  
 6. (c) Age of husband or wife if alive Unknown years  
 7. Birth date of deceased (Unknown) 1885  
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>56</u>			hr. _____ min.

9. Birthplace North Dakota  
 (City, town, or county) (State or foreign country)

10. Usual occupation Laborer

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

MOTHER FATHER  
 12. Name Unknown  
 13. Birthplace Unknown  
 (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 State Hospital No. 4 Records  
 (b) Address Farmington, Missouri

17. (a) Burial (b) Date thereof 11-16-41  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Rolla, Mo.

18. (a) Signature of funeral director Null and form  
 (b) Address Rolla, Mo.

19. (a) 11-14-41 (b) T. J. Robinson  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County Phelps  
 (c) City or town Rolla  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 14th  
 year 1941 hour 3 minute 10 P.M.

21. I hereby certify that I attended the deceased from 10-6-41  
 \_\_\_\_\_, 19\_\_\_\_, to 11-14-41, 19\_\_\_\_;  
 that I last saw him alive on 11-14-41, 19\_\_\_\_;  
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhages  
 Duration 6 wks 11-13-41

Due to Arteriosclerosis, generalized & marked ?

Due to \_\_\_\_\_

Other conditions Psychosis with other disturbance 21 years  
 (Include pregnancy within 3 months of death)

of Circulation  
 Major findings: No operation  
 Of operations \_\_\_\_\_  
 Of autopsy no autopsy of 30'  
 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? \_\_\_\_\_ (e) Means of injury 0

23. Signature C. C. Oelt (M.D. or other) MD  
 Address Farmington Date signed 11/17/41

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

REC-2 15-27

**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..... *S. B. Nunez*  
Licensed Embalmer No..... *3394*  
P. O. Address..... *Rellam*

**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, fact should be so stated above.**