

ED OCT 13 1943  
273

State File No. \_\_\_\_\_  
Registrar's No. 90

Registration District No. \_\_\_\_\_

Primary Registration District No. 5914

1. PLACE OF DEATH:

(a) County **Perry**  
(b) City or town **Rural Cinque Hommes**  
(c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community **72 Years**  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Perry**  
(c) City or town **Rural**  
(d) Street No. \_\_\_\_\_  
(e) Citizen of foreign country? \_\_\_\_\_  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **Susana Zoellner**

3. (b) If veteran, name war \_\_\_\_\_  
3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White**  
6. (a) Single, widowed, married, divorced **Widowed**  
6. (b) Name of husband or wife **Joseph F. Zoellner**  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased **August 11 1865**  
(Month) (Day) (Year)

8. AGE: 78 Years 1 Months 13 Days  
If less than one day hr. min.

9. Birthplace **Germany**  
(City, town, or county) (State or foreign country)

10. Usual occupation **House Wife**

11. Industry or business \_\_\_\_\_  
12. Name **Blasius Buerck**  
13. Birthplace **Germany**  
14. Maiden name **Josephine Rummel**  
15. Birthplace **Germany**

MOTHER FATHER

16. (a) Informant **Mrs. Frank Pingle**  
(b) Address **Biehle RFD #1**

17. (a) **Burial** (b) Date thereof **9-27-1943**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Biehle Mo.**

18. (a) Signature of funeral director **Young & Sons**  
(b) Address **Perryville Mo.**

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **September** 24  
year **1943** hour **5** minute **30 P.M.**

21. I hereby certify that I attended the deceased from **May 15 1943** to **Sept 24 1943**  
that I last saw her alive on **Sept 24 1943**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Apoplexy**  
Due to **Hypertension**  
Due to **Arteriosclerosis**  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Duration **4 mon**  
**2 yrs**

Major findings: \_\_\_\_\_  
Of operations: \_\_\_\_\_  
Of autopsy: \_\_\_\_\_

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? \_\_\_\_\_  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? \_\_\_\_\_  
(Specify type of place) (a) Means of injury \_\_\_\_\_

23. Signature **Ascar Carron** (M. D. or other) \_\_\_\_\_  
Address **Perryville, Mo.** Date signed **9/28/43**

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

1326

RECEIVED

District Health Officer No. 4  
District File Number 1043-2843  
Date Filed 10-11-43

NOV - 4 1943

**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 Wallace Young

Licensed Embalmer No. 4027

P. O. Address Perreault, Me.

**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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. oct

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

- (a) County Perry
- (b) City or town Rural  
(If outside city or town limits, write "RURAL" and name of township)
- (c) Name of hospital or institution: \_\_\_\_\_

(If not in hospital or institution, write street number or location) \_\_\_\_\_

- (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)

In this community 72 yr.  
years, months or days

3. (a) PRINT FULL NAME Susana Zoellner

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

- 4. Sex 7 5. Color or race w
- 6. (a) Single, widowed, married, divorced w

- 6. (b) Name of husband or wife \_\_\_\_\_
- 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Aug. 11-1883  
(Month) (Day) (Year)

8. AGE: Years 78 Months 1 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

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

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 9-25-40 (b) Thos. Zoeller  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Mo. (b) County Perry
- (c) City or town Rural  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location) \_\_\_\_\_

- (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)

If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 24  
year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; \_\_\_\_\_, 19\_\_\_\_;

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;

and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Duration

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

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

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

NOV - 4 1943

32244