

FILED MAY 1944

Registration District No. 1398

Primary Registration District No. 6225

Registrar's No. 72

1. PLACE OF DEATH:

(a) County Vernon  
 (b) City or town Rural Washington Twp  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: State Hosp # 3. 2  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether years, months or days)  
 In this community 27 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Bates  
 (c) City or town Appleton City Mo.  
(If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_  
(If rural, give location)  
 (e) Citizen of foreign country? no (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME William Zimmerman

3. (b) If veteran, name war no 3. (c) Social Security No. ?

4. Sex M 5. Color or Race W 6. (a) Single, widowed, married, divorced Widower  
 6. (b) Name of husband or wife unknown 6. (c) Age of husband or wife if alive ? years  
 7. Birth date of deceased unknown  
(Month) (Day) (Year)

8. AGE: Years 83 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Missouri (City, town, or county) \_\_\_\_\_ (State or foreign country) 0

10. Usual occupation Laborer

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

12. Name unknown

13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country) 9

14. Maiden name unknown

15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country) 9

16. (a) Informant Bates County Clerk

(b) Address Butler Mo

17. (a) Burial (b) Date thereof 9-10-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hosp. Cemetery

18. (a) Signature of funeral director Stehinger

(b) Address Neerds Mo

19. (a) 4-10-44 (b) Dozel B. Beurch  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 7 year 1944 hour 8 minute 45 P.M.

21. I hereby certify that I attended the deceased from 3/10/44 to 4/7/44  
 that I last saw him alive on 4/7/44 and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial degeneration, chronic, Myocarditis

Due to other condition!  
Fracture left femur

Other conditions senile psychosis  
(Include pregnancy within 3 months of death)

Major findings: Of operations none  
 Of autopsy no

22. If death was due to external causes, fill in the following:  
 (a) Accident, suicide, or homicide (specify) no  
 (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? \_\_\_\_\_ (a) Means of injury !

23. Signature Frank M. Rogan (M. D. or other)  
 Address State Hosp # 3 Date signed 4/7/44

Duration

4 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 7,

District File Number 4-44352

Date Filed 5-2-44

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.....

*Mark Eichinger*

Licensed Embalmer No.....

*2656*

P. O. Address.....

*Nevada*

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.

2B  
5-43  
X38930

State File No. May  
Registrar's No. 72

Registration District No. 360 Primary Registration District No. 6225

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

1. PLACE OF DEATH:

(a) County Vernon  
(b) City or town Russell Washington  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: State Hospital #3  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 28 days (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Bates  
(c) City or town Oppeleton city Mo.  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Wallace Zimmerman

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive deceased

7. Birth date of deceased: Unknown (Month) (Day) (Year)

8. AGE: Years 83 Months \_\_\_\_\_ Days \_\_\_\_\_ (If less than one day, min.)

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

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

11. Industry or business Schuer

MOTHER FATHER

12. Name Unknown

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

14. Maiden name Unknown

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

16. (c) Informant Sheriff Bates Co.

(b) Address Butler Mo.  
17. (d) Burial (Burial, cremation, or removal) State thereof 4-8-44 (Month) (Day) (Year)

(c) Place: burial or cremation State Hospital #3

18. (a) Signature of funeral director Erchinger Funeral

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April Day 7 Year 1944 Hour \_\_\_\_\_ Minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_; that I last saw him alive on April - 7 - 44 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death: Myocardial Degeneration  
Due to Chronic Myocarditis  
Due to \_\_\_\_\_  
Other conditions Fracture Left femur  
(Includes pregnancy within 3 months of death)

Major findings: No  
Of operations No  
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) Yes  
(b) Date of occurrence April 14 - 1944  
(c) Where did injury occur? State Hospital #3 (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? State Hospital #3  
While at work? No (Specify type of place) (e) Means of injury fell  
23. Signature Franklin Rogers (M. D. or other)  
Address State Hospital #3 Date signed 5-6-44

SUPPLEMENTARY

10051