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Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED MAY 12 1945

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **3662**

1. PLACE OF DEATH:

(a) County _____
(b) City or town ST. LOUIS MO.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: CITY HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 DAYS
(Specify whether _____)
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County 17
(c) City or town ST LOUIS
(If outside city or town limits, write "RURAL")
(d) Street No. 3931^a SHAW BLVD.
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME FRED GEORGE ZACHRITZ

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

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced 2 WIDOWER

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased. FEB 2 1958
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
87 2 21 hr. min.

9. Birthplace ST. LOUIS MO.
(City, town, or county) (State or foreign country)

10. Usual occupation LAUNDRYMAN

11. Industry or business RETIRED

12. Name FRED ZACHRITZ

13. Birthplace GERMANY 11
(City, town, or county) (State or foreign country)

14. Maiden name HOFFMANN

15. Birthplace GERMANY 11
(City, town, or county) (State or foreign country)

16. (a) Informant L. ARTHUR ZACHRITZ

(b) Address 3931^a SHAW BLVD.

17. (a) BURIAL (b) Date thereof APRIL 26 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation NEW ST. MARCUS CEM.

18. (a) Signature of funeral director Wm. J. Robert D. U. C.

(b) Address 1905 Grand Blvd.

19. (a) APR 25 1945 (b) J. F. Bredeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month APRIL day 23
year 1945 hour 10 minute 30 A.M.

21. I hereby certify that I attended the deceased from _____, 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: Fracture of Rt. Hip Duration
Chronic Coronary Heart Disease
Chronic Angitis Chronic Cystitis
Emphysema
She slipped and fell to the floor at her home on April 18
Due to 1945 slip time unknown

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) Accident 900

(b) Date of occurrence April 18 1945

(c) Where did injury occur? at home
(City or town) (County) (State)

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

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

23. Signature Wm. J. Robert (M. D. or other) _____

Address 1905 Grand Blvd. Date signed 4/25/45

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

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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.....

John G. Pettee

Licensed Embalmer No. *3880*

P. O. Address..... *St. Louis, Mo.*

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.