

FILED AUG 3 1945  
818

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

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

1003

Registrar's No. 6748

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: CITY HOSPITAL  
(If not in hospital of institution, write street number or location)  
(d) Length of stay: In hospital or institution 30 DAY  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County 000  
(c) City or town ST LOUIS  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3900 FOLSOM AVE  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_  
(Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME EDWARD H ZAHN

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 SINGLE

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

7. Birth date of deceased AUG 1 1860  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
84 11 29 hr. min.

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

10. Usual occupation RETIRED

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

MOTHER FATHER  
12. Name HERMAN ZAHN  
13. Birthplace GERMANY  
(City, town, or county) (State or foreign country)  
14. Maiden name SOPHIA HAKE  
15. Birthplace GERMANY  
(City, town, or county) (State or foreign country)

16. (a) Informant CHAS. H. ZAHN  
(b) Address 3900 FOLSOM

17. (a) CREMATION (b) Date thereof AUG 1 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation MISSOURI CREMATOR

18. (a) Signature of funeral director W. J. ROBERT L. & C.  
(b) Address 1905 S. BRAND BLDG

19. (a) JUL 31 1945 (b) J. F. Brodeur  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 30th day July  
year 1945 hour 6 minute 30 M.

21. I hereby certify that I attended the deceased from May 15 1945 to July 30 1945  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Atherosclerosis  
Heart Disease

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

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

Other conditions (Include pregnancy within 3 months of death) 93

Major findings: Of operations none  
Of autopsy none

Duration

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) (b) Means of injury \_\_\_\_\_

23. Signature J. F. Brodeur (M. D. or other) \_\_\_\_\_  
Address 1515 Lafayette Date signed \_\_\_\_\_

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 Ketter* .....  
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.**