

FILED FEB 11 1946

STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 2

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St. Joseph  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
915 South 13th  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community 9 months years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan

(c) City or town St. Joseph  
(If outside city or town limits, write "RURAL")

(d) Street No. 915 South 13th  
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Carrie G. Zimmerman

3. (b) If veteran, name war none

3. (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 2nd  
year 1946 hour 7 minute P M.

4. Sex female 5. Color or race white

6. (a) Single, widowed, married, divorced widow

6. (b) Name of husband or wife George E. Zimmerman

6. (c) Age of husband or wife if alive - years

7. Birth date of deceased February 17 1971  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 12/22, 1945 to 1-2-, 1946  
that I last saw him alive on 12/31, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death  
Cerebral hemorrhage Duration 11 days

Due to Arterio-sclerosis (gen.)

Due to Myocarditis - chr.

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

8. AGE: Years Months Days If less than one day

<u>74</u>	<u>10</u>	<u>15</u>	hr. _____ min.
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9. Birthplace Lowell Michigan  
(City, town, or county) (State or foreign country)

10. Usual occupation at home

Major findings: Of operations none

Of autopsy none

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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

MOTHER FATHER { 12. Name John Calkins

13. Birthplace unknown New York  
(City, town, or county) (State or foreign country)

14. Maiden name Isabelle Merrell

15. Birthplace unknown New York  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Frank Yost

(b) Address 915 South 13th

17. (a) removal (b) Date thereof 1/3 /46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation McCook, Nebr.

18. (a) Signature of funeral director Theater Beale & Bowman

(b) Address 319 South 10th

19. (a) Jan 4-46 (b) H.J. Westphal  
(Date received local registrar) (Registrar's signature)

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 E. T. Bloomer (M. D. or other) M.D.  
Address 1218 N. 30 St. Date signed 1/3/46

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

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Mr. N. J. Blenner  
121877.320  
2-1333

**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 Frank A. Blenner  
Licensed Embalmer No. 1710  
P. O. Address St. Joseph, 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.**