

U. S. No. 2  
FORM-5-43  
Rev. 5-17-39  
I X38671

**FILED SEP 8 1946**

Registrar's No. **7453**

Registration District No. \_\_\_\_\_ Primary Registration District No. **1003**

**1. PLACE OF DEATH:**

(a) County St. Louis

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

(c) Name of hospital or institution:  
Missouri Baptist Hospital 0  
(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 \_\_\_\_\_  
(Specify whether years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Laclede 52

(c) City or town Stoutland h R 5  
(If outside city or town limits, write "RURAL")

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

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No) 1  
If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** William H. Zumwalt

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Clarcie Zumwalt 6. (c) Age of husband or wife if alive 58 years

7. Birth date of deceased March 7 1885  
(Month) (Day) (Year)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month August day 27 year 1946 hour 1 minute 05 P. M.

21. I hereby certify that I attended the deceased from 8/1-46, 19, to 8/27-46, 19, that I last saw him alive on 8/27-46, 19, and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Anoxia Duration \_\_\_\_\_

Due to Sclerosis Cerebral and General

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

Other conditions 83  
(Include pregnancy within 3 months of death)

**8. AGE:**

Years	Months	Days	If less than one day
<u>61</u>	<u>5</u>	<u>20</u>	hr. _____ min. _____

9. Birthplace Laclede County Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Minister

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

**MOTHER FATHER**

12. Name T.J. Zumwalt

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

14. Maiden name Sarah Manes

15. Birthplace Unknown Indiana 1  
(City, town, or county) (State or foreign country)

16. (a) Informant Pearl Percy

(b) Address Richland, Missouri

17. (a) Burial (b) Date thereof 8-31-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Richland, Missouri

18. (c) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) AUG 28 1946 (Date received local registrar) J. Z. Burdick (Registrar's signature)

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)

(c) Means of injury \_\_\_\_\_

23. Signature P. C. Anderson (M. D. or other) 8/28-46  
H. J. M. Co. Co. 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 Henry M. Brammer

Licensed Embalmer No. 4200

P. O. Address.....

**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.**