

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 28 1946

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35758

State File No. _____

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **8805**

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:
5215 Gilmore
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Gas

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

(d) Street No. 5215 Gilmore
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country 11

3. (a) PRINT FULL NAME John A. Zoeller

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Elizabeth S. Schoenberger

6. (c) Age of husband or wife if alive 68 years

7. Birth date of deceased February 4, 1868
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>78</u>	<u>8</u>	<u>8</u>	hr. _____ min. _____

9. Birthplace Dixon, Ill.
(City, town, or county) (State or foreign country)

10. Usual occupation Shoe Worker (Retired)

11. Industry or business _____

MOTHER FATHER

12. Name Charles Zoeller

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

14. Maiden name Margaret Minnie

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

16. (a) Informant Elizabeth S. Zoeller

(b) Address 5215 Gilmore Ave.

17. (a) Burial
(Burial, cremation, or removal)

(b) Date thereof Oct. 15, '46
(Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Bromschwig and Son Funeral Home

(b) Address 4743 W. Florissant Ave.

19. (a) OCT 14 1946
(Date received local registrar)

(b) J. F. Bredek
(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 12
year 1946 hour 7 minute 30 A.M.

21. I hereby certify that I attended the deceased from Oct 15, 1946 to Oct 12, 1946
that I last saw him alive on 10/9, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis

Due to Arteriosclerosis

Other conditions 93
(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) 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? _____

While at work _____ (Specify type of place)

(a) Means of injury 99

23. Signature Charles W. Harris MD
Address 5398 a Page Date signed 10/14/46

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

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 W. Wilkins

Licensed Embalmer No. 3575

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.