

FILED OCT 18 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **35496**
8540

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|---|--|--|--|--|--|---|--|
| BIRTH NO. | | REG. DIST. NO. 318 | | PRIMARY REG. DIST. 1003 | | Registrar's No. | |
| 1. PLACE OF DEATH a. COUNTY | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. | | | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis | | c. LENGTH OF STAY (in this place) | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis | | 2179 | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis State Hospital | | | | d. STREET ADDRESS (If rural, give location) 4140a DeTonty Ave. | | | |
| 3. NAME OF DECEASED (Type or Print) FRANCES | | a. (First) | | b. (Middle) ZINA | | c. (Last) ZABEL | |
| 4. DATE OF DEATH (Month) (Day) (Year) Oct. 9, 1950 | | 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married | |
| 8. DATE OF BIRTH Dec. 27, 1885 | | 9. AGE (In years last birthday) 64 | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Kansas City, Mo. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13a. FATHER'S NAME Unknown | | 13b. MOTHER'S MAIDEN NAME Mary McClain | | 14. NAME OF HUSBAND OR WIFE William Zabel | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Norma Newsom 4140a DeTonty St. | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</i> | | MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Arteriosclerosis | | | | INTERVAL BETWEEN ONSET AND DEATH 1949x | |
| | | ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | | | | |
| | | II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? 332X | | | |
| 22. I hereby certify that I attended the deceased from Jan. 24, 1949 , to Oct. 9, 1950 , that I last saw the deceased alive on Oct. 9, 1950 , and that death occurred at 1:04 P m., from the causes and on the date stated above. | | | | | | | |
| 23a. SIGNATURE Clemens | | | | 23b. ADDRESS 5400 Arsenal St. | | 23c. DATE SIGNED 10/9/50 | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) | | 24b. DATE 10-9-50 | | 24c. NAME OF CEMETERY OR CREMATORY St. Joseph, Mo. | | 24d. LOCATION (City, town, or county) (State) | |
| DATE RECD BY LOCAL REG. OCT 10 1950 | | REGISTRAR'S SIGNATURE J. B. Pasater | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Kriegshauser 4228 S. Kingshighway Bl. | | | |

(Licensed Embalmer's Statement on Reverse Side)

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

8540

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 _____

working under my personal supervision.

Student Embalmer No.

Signed Richard N. Stovesand

Signed
Student Embalmer

Licensed Embalmer No. 4007

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.