

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34376

State File No.

FILED OCT 15 1953

REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

Registrar's No. 9294

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri				b. COUNTY							
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis				c. LENGTH OF STAY (In this place)				c. CITY OR TOWN St. Louis				d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION 6530a Arsenal Street				STREET ADDRESS (If rural, give location) 3 6530a Arsenal Street				3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year) Sept. 24, 1953			
a. (First) Elmer				b. (Middle) H.				c. (Last) Zapf							
5. SEX Male <input type="checkbox"/>		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH June 24, 1893		9. AGE (In years last birthday) 60		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) Attendant				10b. KIND OF BUSINESS OR INDUSTRY St. Louis State Hosp				11. BIRTHPLACE (City and State or Foreign Country) St. Louis Missouri				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13a. FATHER'S NAME George Zapf				13b. MOTHER'S MAIDEN NAME Amelia LaReu				14. NAME OF HUSBAND OR WIFE Theresa Baumann Zapf							
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 Theresa Zapf				ADDRESS 6530a Arsenal St.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Thrombosis</u> ANTECEDENT CAUSES Morbid 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.								INTERVAL BETWEEN ONSET AND DEATH 7 days			
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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 4201											
22. I hereby certify that I attended the deceased from <u>Sept 21, 1953</u> , to <u>Sept 24, 1953</u> , that I last saw the deceased alive on <u>Sept 24, 1953</u> , and that death occurred at <u>9:15A</u> a.m., from the causes and on the date stated above.															
23a. SIGNATURE <u>John S. Matthew MD</u>				23b. ADDRESS <u>3707 W. Watson</u>				23c. DATE SIGNED <u>9-25-53</u>							
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <u>Sept. 28, 1953</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Resurrection Cemetery</u>				24d. LOCATION (City, town, or county) (State) <u>St. Louis Co., Mo.</u>							
DATE REC'D BY LOCAL REG. SEP 28 1953		REGISTRAR'S SIGNATURE <u>J. Carl Smith MD</u>				25. FUNERAL DIRECTOR'S SIGNATURE <u>Wacker-Helders</u>				ADDRESS <u>3634 Gravois Ave.</u>					

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....
Licensed Embalmer No.....
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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.**