

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **7037**

BIRTH NO. **FILED MAR 4 1954** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **1546**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.		c. CITY OR TOWN St. Louis, Mo.	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION. Mo. Baptist		e. STREET ADDRESS (If rural, give location) 5707 Lotus Ave.	

3. NAME OF DECEASED (Type or Print) a. (First) Dr. Victor J Zern Jr.	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) Feb. 15, 1954.
--	-------------	-----------	--

5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, <input checked="" type="checkbox"/> WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH Jan. 26, 1915.	9. AGE (In years last birthday) 39	IF UNDER 1 YEAR Months	IF UNDER 4 HRS. Days	Hours	Min.
-----------------	---------------------------	---	--	---	------------------------	----------------------	-------	------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dr. of Chiropractic, Chiropractor, St. Louis, Mo.	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) C	12. CITIZEN OF WHAT COUNTRY?
---	-----------------------------------	---	------------------------------

13a. FATHER'S NAME Victor J Zernovacz	13b. MOTHER'S MAIDEN NAME Anne Szaker.	14. NAME OF HUSBAND OR WIFE
---	--	-----------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes World War 2	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Rudolph Zern	ADDRESS 4515 Claxton Ave
--	-------------------------	--	------------------------------------

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, ashenia, etc? It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ruptured Esophageal Varices		INTERVAL BETWEEN ONSET AND DEATH summed 3-6 mos.
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Curbsisid of Liver		
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) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 5810

22. I hereby certify that I attended the deceased from **2-5-54**, to **2-15**, 19**54**, that I last saw the deceased alive on **2-15**, 19**54**, and that death occurred at **7:15 P m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) John J. Kennedy M.D. ChM	23b. ADDRESS 8733 Riverview	23c. DATE SIGNED 2-17-54
---	---------------------------------------	------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Feb. 18, 1954.	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery.	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.
--	------------------------------------	--	--

DATE REC'D BY LOCAL REG. FEB 17 1954	REGISTRAR'S SIGNATURE J. Carl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE J. J. Quinn.	ADDRESS 1389 Union Blv
--	--	---	----------------------------------

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 *Ronald O. York*.....

Licensed Embalmer No. *39*.....

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.