

FILED JAN 20 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1382

State File No.

BIRTH NO. _____ REG. DIST. NO. 146 PRIMARY REG. DIST. NO. 3026 Registrar's No. 6

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, write RURAL and give township) INDEPENDENCE		c. CITY (If outside corporate limits, write RURAL and give township) INDEPENDENCE	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION REST HAVEN		d. STREET ADDRESS (If rural, give location) 9904 WINNER ROAD	

3. NAME OF DECEASED (Type or Print) a. (First) SYBILA	b. (Middle)	c. (Last) ZENOR	4. DATE OF DEATH (Month) (Day) (Year) JAN. 3, 1955
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5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH JUNE 20, 1858	9. AGE (In years last birthday) 96	10. UNDER 1 YEAR Months	11. UNDER 1 HRS. Hours	12. CITIZEN OF WHAT COUNTRY? U. S. A.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED	10b. KIND OF BUSINESS OR INDUSTRY RETIRED	11. BIRTHPLACE (City and State or Foreign Country) SPRINGVILLE, UTAH	12. CITIZEN OF WHAT COUNTRY? U. S. A.
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13a. FATHER'S NAME DR. FRANK ALLEN	13b. MOTHER'S MAIDEN NAME NO RECORD PIDD	14. NAME OF HUSBAND T. H. ZENOR
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME MRS. ALVIN KNAPP	ADDRESS LYNCH ENR. NEBR.
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Arteriosclerosis years		
	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"/>
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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)
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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
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22. I hereby certify that I attended the deceased from 12/14, 1954, to 1/3, 1955, that I last saw the deceased alive on 12/21, 1954, and that death occurred at 4:30 A.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Chas. Groszke, M.D.	23b. ADDRESS Independence, Mo.	23c. DATE SIGNED 1/3/54
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE JAN. 4, 1955	24c. NAME OF CEMETERY OR CREMATORY ROSE HILL	24d. LOCATION (City, town, or county) (State) LAMONI IOWA
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DATE REC'D BY LOCAL REG. 1-4-55	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE [Signature]	ADDRESS INDEPENDENCE MO
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(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
Student Embalmer

Signed John R. Bidmer

Licensed Embalmer No. 4531

P. O. Address Kansas City, Mo.

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.