

FILED AUG 22 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 29512

BIRTH NO. _____		REG. DIST. NO. <u>317</u>		PRIMARY REG. DIST. NO. <u>590</u>		Registrar's No. <u>1854</u>	
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).			
a. COUNTY <u>St. Louis</u>		b. CITY (If outside corporate limits, write RURAL and give township) <u>Rural Wellston</u>		c. LENGTH OF STAY (In this place) <u>3 days</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. CITY OR TOWN <u>St. Louis</u>		a. STATE <u>Missouri</u>		b. COUNTY <u>St. Louis</u>		e. STREET ADDRESS (If rural, give location) <u>2134 Edmund</u>	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
a. (First) <u>Adam</u>		b. (Middle)		c. (Last) <u>Zorn</u>		Aug. 2, 1956	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Mar. 9, 1875</u>	
9. AGE (In years last birthday) <u>81</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cutter</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Summerfield, Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Peter Zorn</u>		13b. MOTHER'S MAIDEN NAME <u>Catherine Daget</u>		14. NAME OF HUSBAND OR WIFE <u>Mrs. Ida Zorn</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>498-09-16173</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Ida Zorn, wife. Same address as pt.</u>			
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, asthma, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>arteriosclerotic heart disease</u>  ANTECEDENT CAUSES <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i> DUE TO (b) _____ DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>				INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u>	
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) <u>—</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>4200</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>—</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>—</u>			
22. I hereby certify that I attended the deceased from <u>7-30</u> , 19 <u>56</u> , to <u>8-2</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>8-1</u> , 19 <u>56</u> , and that death occurred at <u>4:10 a m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Paul T. Hartman M.D.</u>				23b. ADDRESS <u>6376 Clayton Rd</u>		23c. DATE SIGNED <u>8-2-56</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>8/6/56</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Keystone Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Jacob, Illinois</u>	
DATE REC'D BY LOCAL REG. <u>8-3-56</u>		REGISTRAR'S SIGNATURE <u>Herbert B. Donk</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Drehmann-Harral 1905 Union Blvd.</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..... *Albert R. Thompson*

Licensed Embalmer No. *425*

P. O. Address *H. Davis*

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.