

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED NOV 16 1956

State File No. **36446**
Registrar's No. **8999**

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 8999	
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 town(ship)) 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 St. John's Hospital				• STREET ADDRESS (If rural, give location) 9247 1/2 2110a Wyoming			
3. NAME OF DECEASED (Type or Print) OSCAR		a. (First)		b. (Middle)		c. (Last) ZAHN	
4. DATE OF DEATH (Month) (Day) (Year) 9 29 56		5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH 10-14-1878		9. AGE (In years last birthday) 77		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) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Justis Zahn		13b. MOTHER'S MAIDEN NAME Josephine Heine		14. NAME OF HUSBAND OR WIFE Maude Zahn			
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 Maude Zahn, 2110a Wyoming			
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Abnormal</u> ANTECEDENT CAUSES As for the conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>hypertension</u> DUE TO (c) <u>arteriosclerotic heart disease</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4200	
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? _____					
22. I hereby certify that I attended the deceased from <u>Sept. 14, 1956</u> , to <u>Sept. 29, 1956</u> , that I last saw the deceased alive on <u>Sept. 29, 1956</u> , and that death occurred at <u>9:30 p.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Thornton C. Wall MD.</u>				23b. ADDRESS <u>Maplewood 17, Mo.</u>		23c. DATE SIGNED <u>10-1-56</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 10-2-1956		24c. NAME OF CEMETERY OR CREMATORY Lake Charles Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis Co., Missouri	
DATE REC'D BY LOCAL REG. OCT 2 1956		REGISTRAR'S SIGNATURE <u>Carl Smith MD.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS McLaughlin F.H., Inc., 2301 Lafayette			

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 *L. P. Cooper*.....

Licensed Embalmer No. *36335*

P. O. Address *2317 Pa*

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.