

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-008002  
State File No.

FILED FEB 28 1958

REG. DIST. NO. 318

PRIMARY REG. DIST. NO. 1003

Registrar's No. 1879

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 1879	
1. PLACE OF DEATH a. COUNTY <u>St. Louis</u> b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>St. Louis, Mo.</u> ) c. LENGTH OF STAY (in this place) <u>10 days</u> d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Louis Children's Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Illinois</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN <u>Litchfield</u> d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> e. STREET ADDRESS (If rural, give location) <u>32 R. R. #2</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Mary</u> b. (Middle) <u>Jo</u> c. (Last) <u>Zarr</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 16, 1958</u>		5. SEX <u>F.</u>		6. COLOR OR RACE <u>W.</u>	
7. MARRIED, NEVER MARRIED, <input checked="" type="checkbox"/> WIDOWED, DIVORCED (Specify) <u>Never married</u>		8. DATE OF BIRTH <u>July 17, 1957</u>		9. AGE (In years last birthday) <u>7</u> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 12 HRS.: Hours _____ Min. _____		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Hillsboro, Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13a. FATHER'S NAME <u>George Zarr</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Fudoli</u>		14. NAME OF HUSBAND OR WIFE <u>None</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>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Ida Leib</u> ADDRESS _____			
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Laryngo-spasm due to aspiration gastric contents with bilateral atelectasis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Gilberious peritonitis</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <u>derodermatitis interofrenica</u> Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>5 hrs</u> <u>2 days</u> <u>1 1/2 hrs</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>576x</u>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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. HOW DID INJURY OCCUR? _____	
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"/>		22. I hereby certify that I attended the deceased from <u>2-6-58</u> , 19 <u>58</u> , to <u>2-16-58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>2-16-58</u> , 19 <u>58</u> , and that death occurred at <u>3:00 a.</u> m., from the causes and on the date stated above.			
23a. SIGNATURE <u>J. H. Middelkamp M.D.</u> (Degree or title)		23b. ADDRESS <u>Children's Hospital</u>		23c. DATE SIGNED <u>FEB 17 '58</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>2-16-58</u>		24c. NAME OF CEMETERY OR CREMATORY _____		24d. LOCATION (City, town, or county) (State) <u>Benld, Ill.</u>	
DATE REC'D BY LOCAL REG. <u>FEB 17 '58</u>		REGISTRAR'S SIGNATURE <u>Carl Smith M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Albert H. Hoppe</u> ADDRESS <u>4700 Washington Blvd.</u>			

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Carl Smith M.D.  
m & B (Licensed Embalmer's Statement on Reverse Side)

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**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 *Robert M. Murray*.....

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.