Health, Welfare Public Service

300
1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-031144
STATE FILE NUMBER

FILED SEP 11 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8500

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) St. Louis, Missouri — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) BARNES HOSPITAL — Length of stay in 1b: 1 day

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo.
b. COUNTY
c. CITY OR TOWN St. Louis — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 4634 Steinlage Dr. — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First: WALTER Middle: PAUL Last: ZEIP

4. DATE OF DEATH Month: 9 Day: 1 Year: 58

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct. 19, 1895
9. AGE (In years last birthday): 62 — 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): Credit Mgr. - Ret.
10b. KIND OF BUSINESS OR INDUSTRY: Dept. Store
11. BIRTHPLACE (City and state or country): St. Louis County Mo. U.S.A.
12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME: John Zeip
13b. MOTHER'S MAIDEN NAME: Sophia Jacobsmeyer
14. NAME OF HUSBAND OR WIFE: Hazel Zeip

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): W W I
16. SOCIAL SECURITY NO.: 492-10-5606
17. INFORMANT: Mrs. Hazel Zeip, 4634 Steinlage Dr.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hemorrhage into the esophagus, acute — INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Cancer of the esophagus — 2 yrs.
DUE TO (c) 150X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 7/24/57, to 9/1/58 and last saw him alive on 9/1/58
Death occurred at 6:40 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE H. Bradley (Degree or title) M.D.
22b. ADDRESS BARNES HOSPITAL
22c. DATE SIGNED 9/1/58

23a. BURIAL, CREMATION, REMOVAL (Specify): removal
23b. DATE: 9/4/58
23c. NAME OF CEMETERY OR CREMATORY: Salem Cemetery
23d. LOCATION (City, town, or county) (State): Black Jack Mo.

24. FUNERAL DIRECTOR: Drehmann-Harral
ADDRESS: 1905 Union
25. DATE RECD. BY LOCAL REG.: SEP 3 58
26. REGISTRAR'S SIGNATURE: J. Carl Smith MD

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in Item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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. 4257

P. O. Address St. Louis

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.