

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-008283

STATE FILE NUMBER

FILED APR 7 1959 Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 109

1. PLACE OF DEATH a. COUNTY <b>Adair</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>Adair</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kirksville</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Kirksville</b> <b>0013</b> <b>6</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>207 E. Patterson St.,</b>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <b>207 E. Patterson St.,</b>
3. NAME OF DECEASED (Type or print) First <b>Alma</b> Middle <b>K.</b> Last <b>Zoller</b>		4. DATE OF DEATH Month <b>Apr.</b> Day <b>2,</b> Year <b>1959</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 8, 1890</b>
9. AGE (In years (at birthday)) <b>69</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nurse</b>	11. BIRTHPLACE (City and state or country) <b>Quincy, Illinois</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nurse</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Nurse</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13a. FATHER'S NAME <b>David Zoller</b>		13b. MOTHER'S MAIDEN NAME <b>Louisa Ernst</b>	14. NAME OF HUSBAND OR WIFE <b>X</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, if unknown) (If yes, give year or dates of service) <b>Yes W. W. I</b>		16. SOCIAL SECURITY NO.	17. INFORMANT <b>Albert E. Zoller, Tiffin, Ohio</b>
18. CAUSE OF DEATH (Enter one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute coronary occlusion.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 hours.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Hypertension, essential.</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <b>4251</b>
21. I attended the deceased from Death occurred at <b>Dec. 1938</b> to <b>Apr. 2, 1959</b> and last saw her alive on <b>April 1st 1959</b> .		on the date stated above; and to the best of my knowledge, from the causes stated.	
21a. SIGNATURE (Degree or title) <b>Spencer L. Freeman M.D.</b>		21b. ADDRESS <b>Kirksville, Mo.</b>	21c. DATE SIGNED <b>Apr. 3, 1959</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>4/6/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Quincy, Illinois</b>
24. FUNERAL DIRECTOR <b>Paul W. Kelly</b>		ADDRESS <b>Kirksville, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>4-3-1959</b>
		26. REGISTRAR'S SIGNATURE <b>Doris W. Pothoff</b>	

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare, Public Service

300  
-57

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

SPENCER L. FREEMAN M.D.  
All diseases in Part I must be causally related.

APR 10 1953

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 *Kenneth E. Hayes*

Licensed Embalmer No. *4890*

P. O. Address *Kirksville, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.