

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-016012
STATE FILE NUMBER

FILED MAY 14 1959 Registration District No. Primary Registration District No. Registrar's No. 4247

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 6141 Louisiana		d. STREET ADDRESS (If outside, give location) 6141 Louisiana	
3. NAME OF DECEASED (Type or print) First Middle Last Charles J. Zeller		4. DATE OF DEATH Month Day Year Apr. 29, 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 15, 1882
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Electrician		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) St. Louis, Mo.
13a. FATHER'S NAME Christ Zeller		13b. MOTHER'S MAIDEN NAME Louise Stohr	14. NAME OF HUSBAND OR WIFE Frances Zeller
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) (If yes, give dates of service) no		16. SOCIAL SECURITY NO.	17. INFORMANT Address Frances Zeller 6141 Louisiana
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Bremidity DUE TO (c) +20.0			INTERVAL BETWEEN ONSET AND DEATH Arterio
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Primary Lateral Sclerosis Spinal Cord			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 <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 COUNTY STATE	
21. I attended the deceased from July 1, 54 to April 29, 59 and last saw him alive on April 29, 1959 Death occurred at 10 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Roy C. Ruppel M.D.		22b. ADDRESS 7702 Lemay Ln	
22c. DATE SIGNED 4/30/59			
23b. DATE 5-2-59		23c. NAME OF CEMETERY OR CREMATORY Parklawn C. M.	
23d. LOCATION (City, town, or county) (State) Lemay 23, Mo.			
24. FUNERAL DIRECTOR ADDRESS Southern Funeral Home 6322 S. Grand, St. Louis, Mo.		25. DATE RECD. BY LOCAL REG. APR 30 '59	
26. REGISTRAR'S SIGNATURE Earl Smith, M.D.			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

1-57
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Dr Klupp
7702 Ivory
-til 1 P.M.

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 *David Ken Tinsley*

Licensed Embalmer No. *4312*
P. O. Address *St. Louis 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.