

Health, Welfare, Public Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-019808  
STATE FILE NUMBER  
2 5070  
Registration District No. Primary Registration District No. Registrar's No.

FILED JUN 4 1959

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-57

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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Johns Hospt</b>		d. STREET ADDRESS (If outside, give location) <b>5915 Theodosia Ave</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>John William Zink Sr.</b>		4. DATE OF DEATH Month Day Year <b>May 24 1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 11 1885</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Self-Emp</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tailor</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri</b>
13a. FATHER'S NAME <b>N. Zink</b>		13b. MOTHER'S MAIDEN NAME <b>Marie Lunkhole</b>	14. NAME OF HUSBAND OR WIFE <b>Mary Zink Dec.</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>494 36 7958a</b>	17. INFORMANT Address <b>Norman Zink 5915 Theodosia Ave.</b>
18. CAUSE OF DEATH (Enter only one cause on line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Cerebral arteriosclerosis</b> DUE TO (c) <b>Under 332X</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 mo</b>
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.		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE <b>April 59 24 May 59 23 May 59</b>	
21. I attended the deceased from Death occurred at <b>8:30 am</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>R. B. Beard</b>		22b. ADDRESS <b>6000 Flourant St</b>	
22c. DATE SIGNED <b>25 May 59</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>5-27-59</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis, Missouri</b>	
24. FUNERAL DIRECTOR ADDRESS <b>J. W. Clark F. H. 1125 Hodiadmont Ave</b>		25. DATE RECD. BY LOCAL REG. <b>MAY 26 59</b>	
		26. REGISTRAR'S SIGNATURE <b>Loan Smith, M.D.</b>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Alfred J. Boehner* .....  
Licensed Embalmer No. *2463* .....  
P. O. Address *11257 Hodges* .....

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.