

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-020666

FILED JUL 1 1959

Registration District No. 59 Primary Registration District No. 4077 STATE FILE NUMBER
Registrar's No. 114

1. PLACE OF DEATH a. COUNTY <u>CASS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>CASS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>HARRISONVILLE</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>HARRISONVILLE</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>705 Butler Dr.</u>		d. STREET ADDRESS (If outside, give location) <u>705 Butler Dr</u>	
Length of stay in 1b <u>11 yrs</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MICHAEL</u> Middle <u>HENRY</u> Last <u>ZELLER</u>			4. DATE OF DEATH Month <u>June</u> Day <u>23</u> Year <u>1959</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 19, 1885</u>
9. AGE (In years last birthday) <u>74</u>		10. UNDER 1 YEAR Months _____ Days _____	11. UNDER 24 HRS Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MINISTER</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and state or country) <u>St Louis, Missouri</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Michael H. Zeller</u>	
13b. MOTHER'S MAIDEN NAME <u>Elizabeth Berkamp</u>		14. NAME OF HUSBAND OR WIFE <u>MABEL S. Zeller</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>misplac ed</u>	17. INFORMANT Address <u>Mrs. M.H. Zeller Harrisonville, Mo.</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>MYOCARDIAL INFARCTION</u> DUE TO (c) <u>CORONARY OCCLUSION</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 wks</u> <u>6 wks</u> <u>6 wks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4201</u>			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 _____ a.m. _____ p.m. Month, Day, Year _____			
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 <u>MAY 1 1959</u> to <u>JUNE 23 1959</u> and last saw him alive on <u>JUNE 22 1959</u> Death occurred at <u>3 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>[Signature]</u> MD (Degree or title)		22b. ADDRESS <u>HARRISONVILLE Mo</u>	
22c. DATE SIGNED <u>6-25-59</u>		23a. BURIAL, CREMATION, REMOVAL (Specify)	
23b. DATE <u>June 27-1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oakland Cemetery</u>	
23d. LOCATION (City, town, or county) <u>Harrisonville, Mo.</u>		(State)	
24. FUNERAL DIRECTOR <u>Watson Dickey Harrisonville, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>6-28-59</u>	
26. REGISTRAR'S SIGNATURE <u>Mrs. Ray Sebra</u>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

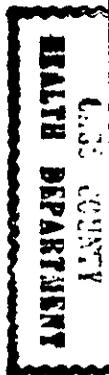
MEDICAL CERTIFICATION

Health, Welfare Public Service

300 -57

All diseases in Part I must be causally related.

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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 W. Utthman*

Licensed Embalmer No. *4902*
P. O. Address *Harrisonville*

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.