

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 46 1 17

FILED VS DEC 21 1959

211455

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo</i> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>ST. LOUIS Mo</i>		c. CITY OR TOWN <i>ST. LOUIS</i>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>ST. ANTHONY'S Hosp.</i>		d. STREET ADDRESS (If outside, give location) <i>4470 OSCEOLA</i>	

3. NAME OF DECEASED (Type or print) First <i>STELLA</i> Middle <i>ZULAUF</i> Last	4. DATE OF DEATH Month <i>DEC.</i> Day <i>9</i> Year <i>1959</i>
--	---

5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>AUG. 28 1891</i>	9. AGE (last birthday) <i>68</i>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
----------------------	-------------------------------	---	--------------------------------------	----------------------------------	--------------------------------	------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>RETIRED SALESLADY</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>FAMOUS-BARR</i>	11. BIRTHPLACE (City and state or country) <i>ST. LOUIS Mo</i>	12. CITIZEN OF WHAT COUNTRY <i>U. S. A.</i>
--	--	--	---

13a. FATHER'S NAME <i>JOSEPH LATEL</i>	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE <i>HENRY ZULAUF</i>
--	---------------------------	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address <i>MILTON ZULAUF 5727 NOTTINGHAM</i>
--	-------------------------	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i>		<i>2 months</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <i>Arteriosclerotic Heart Disease</i>	<i>2 months</i>
	DUE TO (c) <i>Valvular of Aortic Aortic Stenosis</i>	<i>1 day</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>420.0</i>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 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 COUNTY STATE
--	--	---

21. I attended the deceased from *4/26/59* to *12/9/59* and last saw her *live* on *12/9/59*
Death occurred at *4:36* a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22. SIGNATURE (Degree or title) <i>Walter D. Dumbauld</i>	22b. ADDRESS <i>4617 Wabasha Ave</i>	22c. DATE, SIGNED <i>12/9/59</i>
---	--------------------------------------	----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <i>REMOVAL</i>	23b. DATE <i>DEC. 17 1959</i>	23c. NAME OF CEMETERY OR CREMATORY <i>SUNSET BURIAL PK.</i>	23d. LOCATION (City, town, or county) (State) <i>ST. LOUIS Mo</i>
--	-------------------------------	---	---

24. FUNERAL DIRECTOR ADDRESS <i>Thomas Kutas 2906 Travis</i>	25. DATE RECD. BY LOCAL REG. <i>DEC 10 1959</i>	26. REGISTRAR'S SIGNATURE <i>Earl Smith M.D.</i>
--	---	--

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

mjb.

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

Eleana Province

Licensed Embalmer No. 3403

P. O. Address 2906 Grove

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.