

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-009117

FILED VS MAR 7 1960

2 2140

STATE FILE NUMBER

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

1. PLACE OF DEATH a. COUNTY _____ b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis Mo. Length of stay in 1b _____ c. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hosp. # 1 Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY _____ c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS 2723 Caroline (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last RUDOLPH Julius ZORN			4. DATE OF DEATH Month Day Year Feb. 22, 1960				
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 4/16/84	9. AGE (last birthday) 75	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) Laborer		10b. KIND OF BUSINESS OR INDUSTRY American Box Co		11. BIRTHPLACE (City and state or country) Germany USA			
13a. FATHER'S NAME Karl Zorn		13b. MOTHER'S MAIDEN NAME Cecilia Unknown		14. NAME OF HUSBAND OR WIFE Minnie Thurm Zorn			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 495 16 9239		17. INFORMANT Address Minnie Zorn 2723 Caroline			
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>cerebrovascular disease</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>334x</u>					INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N. <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 <u>2/20/60</u> to <u>2/22/60</u> and last saw <u>him</u> alive on <u>2/22/60</u> Death occurred at <u>4:45 p.m.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Dixon Sperry, M.D.</u>			22b. ADDRESS <u>1515 Lafayette Ave.</u>		22c. DATE SIGNED <u>2/23/60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE <u>2/25/60</u>	23c. NAME OF CEMETERY OR CREMATORY St. Trinity Lutheran		23d. LOCATION (City, town, or county) (State) St. Louis City Mo		
24. FUNERAL DIRECTOR ADDRESS E.J. Schnur 3125 Lafayette			25. DATE RECD. BY LOCAL REG. FEB 24 1960		26. REGISTRAR'S SIGNATURE <u>Loan Smith, M.D.</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

277623

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Thomas R. Fenwick

Licensed Embalmer No. 379

P. O. Address 3125 Log

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to do so 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.