

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-020254

FILED VS JUN 6 1960

Registration District No. _____ Primary Registration District No. **3048** Registrar's No. **189**

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY Nodaway				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Nodaway					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Maryville		Length of stay in lb 6 days		c. CITY OR TOWN Maryville		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Francis Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 4 miles northwest		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First KARL Middle E. Last ZIMMERMAN				4. DATE OF DEATH Month 5 Day 24 Year 60					
5. SEX Female male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 12/27/87		9. AGE (last birthday) 72		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own account		11. BIRTHPLACE (City and state or country) Amazonia, Mo.		12. CITIZEN OF WHAT COUNTRY USA			
13a. FATHER'S NAME Edwin Zimmerman			13b. MOTHER'S MAIDEN NAME Susan Horner			14. NAME OF HUSBAND OR WIFE man Eleanor Sawyers Zimmer-			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				17. INFORMANT Address Mrs. John Schrier, Maryville, Mo.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Receipt of thoracic Aorta DUE TO (b) Dissecting Aneurysm of thoracic Aorta DUE TO (c) Generalized Arteriosclerosis & hypertension PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Bee sting on face - same day that illness began. PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown								INTERVAL BETWEEN ONSET AND DEATH Sudden 5 days Several years	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) Bee sting on face						
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 May 17, 1960 to 5/24/60 and last saw ^{her} him alive on May 23, 1960 Death occurred at 2:00 A. m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) M. D.				22b. ADDRESS Maryville, Missouri			22c. DATE SIGNED 6/2/60		
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 5/26/60		23c. NAME OF CEMETERY OR CREMATORY Miriam		23d. LOCATION (City, town, or county) (State) Maryville, Missouri			
24. FUNERAL DIRECTOR Price Funeral Home, Maryville, Mo.			25. DATE RECD. BY LOCAL REG. 6-2-60		26. REGISTRAR'S SIGNATURE Bess Bolt				

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

JUN 21 1960

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

John W. Price

Licensed Embalmer No. 4281

P. O. Address Maryville

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

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

1. PLACE OF DEATH a. COUNTY <u>Nodaway</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Nodaway</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Maryville</u>			Length of stay in lb <u>6 days</u>		c. CITY OR TOWN <u>Maryville</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Francis Hospital</u>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>4 miles northwest</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>KARL</u> Middle <u>E.</u> Last <u>ZIMMERMAN</u>				4. DATE OF DEATH Month <u>5</u> Day <u>24</u> Year <u>60</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12/27/87</u>	9. AGE (last birthday) <u>72</u>	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) <u>Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own account</u>		11. BIRTHPLACE (City and state or country) <u>Amazonia, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Edwin Zimmerman</u>			13b. MOTHER'S MAIDEN NAME <u>Susan Horner Kelly</u>			14. NAME OF HUSBAND OR WIFE <u>man Eleanor Sawyers Zimmer-</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>				17. INFORMANT Address <u>Mrs. John Schrier, Maryville, 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>Rupture of thoracic Aorta</u> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> DUE TO (b) <u>Dissecting Aneurysm of thoracic Aorta</u> <u>5 days</u> DUE TO (c) <u>Generalized Arteriosclerosis & hypertension</u> <u>Several years</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Bee sting on face - same day that illness began.</u>					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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 checked="" 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 17, 1960</u> to <u>5/24/60</u> and last saw her/him alive on <u>May 23, 1960</u> Death occurred at <u>2:00 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>W.R. Jackson M. D.</u>				22b. ADDRESS <u>Maryville, Missouri</u>		22c. DATE SIGNED <u>6/2/60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE <u>5/26/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Miriam</u>		23d. LOCATION (City, town, or county) (State) <u>Maryville, Missouri</u>			
24. FUNERAL DIRECTOR <u>Price Funeral Home, Maryville, Mo.</u>		ADDRESS		25. DATE RECD. BY LOCAL REG. <u>6-2-60</u>	26. REGISTRAR'S SIGNATURE <u>Bess Bolt</u>			

instead of Susan Horner

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF Funeral home 3-25-93

Susan Kelly

