

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

11760

State File No. \_\_\_\_\_

Registration District No. 571

Primary Registration District No. 5769

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:  
(a) County Moniteau  
(b) City or town \_\_\_\_\_  
(c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location) 2  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo (b) County Moniteau  
(c) City or town Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. Walker St  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years

3. (a) PRINT FULL NAME Mary Lue Zimmerman, 565  
(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Mar, day 12, year 1940 hour 8 minute P M.  
21. I hereby certify that I attended the deceased from Mar 6, 1940 to Mar 12, 1940  
that I last saw her alive on Mar 11, 1940  
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced \_\_\_\_\_  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

Immediate cause of death \_\_\_\_\_  
Encephalitis  
Due to \_\_\_\_\_  
Rachitis  
Due to \_\_\_\_\_

7. Birth date of deceased March 6 5 1940  
(Month) (Day) (Year)  
8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days 7 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

9. Birthplace Moniteau Co \_\_\_\_\_  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name George H Zimmerman

13. Birthplace Brazito, Mo \_\_\_\_\_  
(City, town, or county) (State or foreign country)

14. Maiden name Clara B Blythe \_\_\_\_\_  
(City, town, or county) (State or foreign country)

15. Birthplace Been County, Mo \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature George H Zimmerman  
(b) Address Center town Mo

17. (a) Burial (b) Date thereof March 14 40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New Hope

18. (a) Signature of funeral director Jack Bowlin  
(b) Address California, Mo

19. (a) 3-16-40 (b) HR Popejoy 504  
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_

23. Signature Walter G Leslie (M. D. or other) \_\_\_\_\_  
Address Russellville Mo Date signed \_\_\_\_\_

Duration

6 days

PHYSICIAN

Underline the cause to which death should be charged statistically

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Rev. 5-17-30 I 119511

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UNIFORM

STATE OF NEW YORK

OFFICE OF THE

COMMISSIONER OF HEALTH

**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 \_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_, working under my personal supervision.

Signed \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P.O. Address \_\_\_\_\_

**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 this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 11760

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 371

Primary Registration District No. 5769

Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County. Moniteau  
(b) City or town. Waller - Ins  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
in this community \_\_\_\_\_ years, months or days)

3. (a) PRINT FULL NAME Mary Lou Zimmerman

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced \_\_\_\_\_

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ year

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
7 hr. min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

20. DATE OF DEATH Month Mar day 12 year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19 \_\_\_\_\_ to \_\_\_\_\_ 19 \_\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19 \_\_\_\_\_ and that death occurred on the date and hour stated above.

Immediate cause of death encephalitis Duration \_\_\_\_\_  
Was not epidemic

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) 75

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of injury) (e) Means of injury \_\_\_\_\_

23. Signature Walter L. Leslie (Print name or other)

Address Russellville

SUPPLEMENTAL

PHYSICIAN

Underline the cause to which death should be charged statistically.

11760 (1940)