

FILED OCT 21 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34180

State File No.

BIRTH NO.		REG. DIST. NO. <u>221</u>		PRIMARY REG. DIST. NO. <u>5793</u>		Registrar's No. <u>16</u>		
1. PLACE OF DEATH a. COUNTY <u>MONITEAU</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>MONITEAU</u>				
b. CITY (If outside corporate limits, write RURAL and give township) <u>(RURAL) LINN</u>		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) <u>(RURAL) LINN</u>		d. STREET ADDRESS (If rural, give location) <u>NEAR CEDRON Mo.</u>		
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>NEAR CEDRON Mo</u>				d. STREET ADDRESS (If rural, give location) <u>NEAR CEDRON Mo.</u>				
3. NAME OF DECEASED (Type or Print) <u>FRANK</u>			a. (First)		b. (Middle) <u>V</u>		c. (Last) <u>ZEY</u>	
4. DATE OF DEATH <u>Oct. 15 1950</u>		8. DATE OF BIRTH <u>MARCH 20 1875</u>		9. AGE (in years last birthday) <u>75</u>		IF UNDER 1 YEAR Months Days Hours Min.		
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARM OWNER</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARM OWNER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMER</u>		11. BIRTHPLACE (State or foreign country) <u>MISSOURI</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>		
13a. FATHER'S NAME <u>JOHN ZEY</u>			13b. MOTHER'S MAIDEN NAME <u>LOUISE BAKER</u>			14. NAME OF HUSBAND OR WIFE <u>ANNA ZEY (DEAD)</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>No</u>		17. INFORMANT'S SIGNATURE OR NAME (ADDRESS) <u>Ed Sel. Brown, Home Mo</u>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Apoplexy</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arterio-sclerosis</u> DUE TO (c) <u>Hypertension</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?				
22. I hereby certify that I attended the deceased from <u>Oct 1, 1950</u> , to <u>Oct 15, 1950</u> , that I last saw the deceased alive on <u>Oct 9, 1950</u> , and that death occurred at <u>5:15 P.M.</u> , from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <u>M. L. Deekwege M.D.</u>				23b. ADDRESS <u>Bronaue Mo</u>		23c. DATE SIGNED <u>10/16/50</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Oct 17-1950</u>		24c. NAME OF CEMETERY OR CREMATORY <u>CEDRON CATH. CEM.</u>		24d. LOCATION (City, town, or county) (State) <u>CEDRON Mo.</u>		
DATE REC'D BY LOCAL REG. <u>Oct 18-1950</u>		REGISTRAR'S SIGNATURE <u>Gada M. Snow</u>		199 25. FUNERAL DIRECTOR'S SIGNATURE <u>G. Albert Hornbeck</u>		ADDRESS - <u>Bronaue Home Mo</u>		

(Licensed Embalmer's Statement on Reverse Side)

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

p. 300
0.48

RECEIVED
DISTRICT HEALTH DEPT. No. 210

District File Number

Date Filed 10-20-57

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 _____
Student Embalmer

Signed *C. Albert Hornbeck*

Licensed Embalmer No. *2714*

P. O. Address *Brairie Home, Ill.*

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, fact should be so stated above.

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