

10-47  
17-39  
3906

FILED OCT 29 1948  
Registration District No. 149

Primary Registration District No. 1002

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution K. C. T. B. HOSPITAL  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 mo. 27 days  
(Specify whether years, months or days)

In this community 32 years  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME JOHN ZOLMAN

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex MALE 5. Color or race WHITE

6. (a) Single, widowed, married, divorced, divorced

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

7. Birth date of deceased March 21 1894  
(Month) (Day) (Year)

8. AGE: Years 64 Months 6 Days 16 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation none

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

12. Name John P. Zolman

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

14. Maiden name Addie Hughes

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

16. (a) Informant MRS. ROBERT GROOM

(b) Address ST. LOUIS, MISSOURI

17. (a) REMOVAL (b) Date thereof OCT-8-1948  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation FARMINGTON, MISSOURI

18. (a) Signature of funeral director D. W. Newman

(b) Address 1401 Bunch, Wash. Blvd.

19. (a) 10-8-48 (b) Theradine Holmes  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson

(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")

(d) Street No. Unknown  
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCTOBER day 7<sup>TH</sup>  
year 1948 hour 7<sup>30</sup> minute \_\_\_\_\_ P.M.

21. I hereby certify that I attended the deceased from June 10  
1948 to Oct. 7 1948

that I last saw him alive on Oct. 7 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis Duration \_\_\_\_\_

Due to stated above

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

Other conditions 13/18  
(Include pregnancy within 3 months of death)

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? 0

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

23. Signature G. K. Landis G. K. Landis  
(M. D. or other)

Address K.C. Hosp. Date signed 10-7-48

PHYSICIAN  
Underline the cause to which death should be charged statistically.

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 Robert Ray

Licensed Embalmer No. 4182

P. O. Address. Kansas City, Mo.

**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.**