

APR 27 1927

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

Do not use this space.

9352

## 1. PLACE OF DEATH

County St Charles  
Township Dardoune  
City Weldon Springs (No. 50)

Registration District No. 760  
Primary Registration District No. 6001

File No. \_\_\_\_\_  
Registered No. 7  
St. \_\_\_\_\_ Ward \_\_\_\_\_

## 2. FULL NAME

Mrs. Annie M.E. Heisel

(a) Residence No. Weldon Springs Mo Ward \_\_\_\_\_  
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

F

## 4. COLOR OR RACE

white

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

married

## 5A. IF MARRIED, WIDOWED, OR DIVORCED

HUSBAND OF  
(OR) WIFE OF

John W. Heisel

## 6. DATE OF BIRTH (MONTH, DAY AND YEAR)

Oct 30 - 1872

## 7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1  
day, hrs.  
or min.

55 4 3

## 8. OCCUPATION OF DECEASED

(a) Trade, profession, or  
particular kind of work

Housework

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

## 9. BIRTHPLACE (CITY OR TOWN)

St Charles Co Mo

(STATE OR COUNTRY)

## 10. NAME OF FATHER

Peter Berg

## 11. BIRTHPLACE OF FATHER (CITY OR TOWN)

St Charles Co Mo

(STATE OR COUNTRY)

## 12. MAIDEN NAME OF MOTHER

Roth

## 13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

St Charles Co Mo

(STATE OR COUNTRY)

## INFORMANT

John W. Heisel  
Weldon Springs Mo

## 15.

FILED

3/4 1927

J. M. Johnson

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-3- 1927

17.

I HEREBY CERTIFY, That I attended deceased from  
May 1, 1927, to May 3, 1927,  
that I last saw her alive on Mar 2, 1927, and that  
death occurred, on the date stated above, at 6 P.M.

## THE CAUSE OF DEATH\* WAS AS FOLLOWS:

82A Apoplexy

CONTRIBUTORY  
(SECONDARY)

14/01

## 18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

8 DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed) M. L. Currier, M. D.

, 19 (Address)

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state  
(1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or  
HOMICIDAL.

## 19. PLACE OF BURIAL, CREMATION, OR REMOVAL

Collerville Mo

## DATE OF BURIAL

3/6 27

## 20. UNDERTAKER

Ed Keithly

## ADDRESS

Dallan Mo.

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

PHYSICS DEPARTMENT

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH  
 County St. Charles Registration District No. 460 File No. ....  
 Township Dardenne Primary Registration District No. 2001 Registered No. ....  
 City (Name) ..... St. .... Ward)

2. FULL NAME Mrs Anne M. E. Heisel  
 (a) Residence No. .... St. .... Ward. ....  
 (Usual place of abode) .....  
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) m

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 30-1872

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
55 | 4 | 3 | .....

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work .....  
 (b) General nature of industry, business, or establishment in which employed (or employer) .....  
 (c) Name of employer .....

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8-9-1927

17. I HEREBY CERTIFY, That I attended deceased from ..... to .....  
 that I last saw him alive on ..... 19....., and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
 .....  
 CONTRIBUTORY (SECONDARY) .....  
 (duration) ..... yrs. .... mos. .... ds.

9. BIRTHPLACE (CITY OR TOWN) .....  
 (STATE OR COUNTRY) .....

10. NAME OF FATHER .....

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....  
 (STATE OR COUNTRY) .....

12. MAIDEN NAME OF MOTHER .....

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....  
 (STATE OR COUNTRY) .....

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH.....  
 DID AN OPERATION PRECEDE DEATH..... DATE OF.....  
 WAS THERE AN AUTOPSY?.....  
 WHAT TEST CONFIRMED DIAGNOSIS?.....  
 (Signed)....., M. D.  
 , 19 (Address) .....

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

14. INFORMANT (Address) .....

15. FILED 3/4 19 27 J. J. ... REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL ..... DATE OF BURIAL .....  
 20. UNDERTAKER ..... ADDRESS .....

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state EXACTLY. AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state EXACTLY. INFORMATION should be carefully supplied. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

SUPPLEMENTARY

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