

1928

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

Do not use this space.

## 1. PLACE OF DEATH

County Jackson  
Township Snider  
City Brain Valley (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

Registration District No. 402  
Primary Registration District No. 5551B

Johnston 9353  
File No. \_\_\_\_\_  
Registered No. 10  
St. \_\_\_\_\_ Ward \_\_\_\_\_

## 2. FULL NAME

August Heidelberger  
(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.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 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 Margaret Heidelberger

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug-3-62

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
65 7 26

## 8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
(c) Name of employer \_\_\_\_\_

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

10. NAME OF FATHER David Heidelberg

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

12. MAIDEN NAME OF MOTHER Katherine Meier

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

14. INFORMANT (Address) Mrs. Margaret Heidelberger  
Brain Valley Mo (Wife)

15. FILED 4/30 1928 J. W. Mann REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 29 1928

17. I HEREBY CERTIFY, That I attended deceased from Mar 29 1928 to Mar 29 1928 that I last saw him alive on Mar 29 1928, and that death occurred, on the date stated above, at 6-30 p.m.

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

Myocardial of Head & Face  
150  
CONTRIBUTORY (SECONDARY) General Debility  
(duration) 9 yrs. mos. ds.

## 18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? 710 DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? 710

## WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) Wm B Johnston M. D.

3/29, 1928 (Address) Brain Valley Mo

\*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 DATE OF BURIAL

Blue Springs Mo (Cemetery) 3-31-28

20. UNDERTAKER ADDRESS

GB Webb Blue Springs Mo



**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.  
 Case No. Jackson Registration District No. 402 File No. \_\_\_\_\_  
 Township Smia Bay Primary Registration District No. 53-5-1-B Registered No. 10  
 City \_\_\_\_\_ (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME August Heidelberg  
 (a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of abode) (If nonresident give city or town and State)  
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

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

|        |       |        |      |  |
|--------|-------|--------|------|--|
| 7. AGE | YEARS | MONTHS | DAYS | IF LESS than 1 day, _____ hrs. or _____ min. |
|--------|-------|--------|------|--|

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 \_\_\_\_\_

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) \_\_\_\_\_

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 29 1928

17. I HEREBY CERTIFY That I attended deceased from Mar 20 1928, to Mar 28, 1928, that I last saw him \_\_\_\_\_ days on Mar 28, 1928, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Empyriasis of head & face! Not traumatic  
 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 10 ds.

CONTRIBUTORY (SECONDARY) General debility  
 (duration) 8 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH \_\_\_\_\_  
 DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_  
 WAS THERE AN AUTOPSY? no  
 WHAT TEST CONFIRMED DIAGNOSIS?  
 (Signed) Wm B. Johnston M. D.  
 , 19 (Address) Grain Valley Mo.

\*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.

14. INFORMANT \_\_\_\_\_  
 (Address) \_\_\_\_\_

15. FILED 6/13 1928 A.W. Mann REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Blue Springs Mo DATE OF BURIAL Mar 31 1928

20. UNDERTAKER H. B. Webb ADDRESS Blue Springs

SUPPLEMENTARY  
 27-28-29-30-31-32-33-34-35-36-37-38-39-40-41-42-43-44-45-46-47-48-49-50-51-52-53-54-55-56-57-58-59-60-61-62-63-64-65-66-67-68-69-70-71-72-73-74-75-76-77-78-79-80-81-82-83-84-85-86-87-88-89-90-91-92-93-94-95-96-97-98-99-100

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE CO.

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