

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—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.

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

Do not use this space.

1508

1. PLACE OF DEATH

County Jackson
Township Kennett
City Kennett

Registration District No. 399
Primary Registration District No. 4002
(No. St. Mary's Hospital)

File No. 97
Registered No. 97
St. 3 Ward

2. FULL NAME

(a) Residence. No. 5346 St. Mary's St. 15 Ward.

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 <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>August 30 - 1898</u>		
7. AGE	YEARS <u>35</u>	MONTHS <u>4</u>
	DAYS <u>18</u>	IF LESS THAN 1 day, hrs. or min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>C. & N. Railroad Terminal</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Train Master</u> (c) Name of employer <u>Burlington</u>		
9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Lava</u>		
PARENTS	10. NAME OF FATHER <u>Robert N. Heisey</u>	
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Fort Madison</u>	
	12. MAIDEN NAME OF MOTHER <u>Katherine Leicht</u>	
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Lava</u>	
14. INFORMANT (Address) <u>Robert N. Heisey</u> <u>Chicago Illinois</u>		
15. FILED <u>Jan 9 1929</u> <u>M. M. Crowe</u> REGISTRAR		

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) <u>January 8 1929</u>	
17. I HEREBY CERTIFY, That I attended deceased from <u>Dec 20 1928</u> to <u>Jan 8 1929</u> that I last saw him alive on <u>Jan 8 1929</u> , and that death occurred, on the date stated above, at <u>8:30 a.m.</u>	
THE CAUSE OF DEATH* WAS AS FOLLOWS: <u>Acute Endocarditis</u> <u>Acute Arteriosclerosis</u> <u>Rheumatism, Chronic</u> (duration) yrs. mos. da. <u>6</u>	
18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH: <u>Yes</u> DID AN OPERATION PRECEDE DEATH? <u>Yes</u> DATE OF <u>Jan 8 1929</u> WAS THERE AN AUTOPSY? <u>Yes</u> WHAT TEST CONFIRMED DIAGNOSIS? (Signed) <u>H. H. Clayton</u> <u>1/8 1929</u> (Address) <u>312 N. Main St. Mo</u>	
*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. <u>St. Mary's Hospital</u>	
PLACE OF BURIAL, CREMATION, OR REMOVAL <u>St. Mary's Hospital</u>	DATE OF BURIAL <u>1-9 1929</u>
20. UNDERTAKER <u>John F. Sheehan</u>	ADDRESS <u>K. C. Mo</u>

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**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 Jackson
Township Haw
City Keosauqua (No. St. Marys Hosp)

Registration District No.

File No.

Primary Registration District No.

Registered No. 97

St. Ward)

2. FULL NAME

(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.

ds.

How long in U.S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

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

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)

14.

INFORMANT
(Address)

15.

FILED

1/9 1929 M. M. Brown
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-8 1929

17.

I HEREBY CERTIFY That I attended deceased from
19....., 19.....

that I last saw h..... alive on....., 19....., and that
death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

CONTRIBUTORY
(PRIMARY)
(SECONDARY)

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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH INK---THIS IS A PERMANENT RECORD

Every item of information should be correctly stated. 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.

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

SUPPLEMENTARY

S-1508