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

Do not use this space.

53

File No. .....

Registered No. 14

1. PLACE OF DEATH

County Andrain

Township .....

City Mount Ma (No. ..... St. ..... Ward)

Registration District No. 26

Primary Registration District No. 5034

2. FULL NAME Robert G. Heizer

(a) Residence. Nos. Mount Ma 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: 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 Mary O. Heizer

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov-16-1857

7. AGE: Years 77 | Months 1 | Days 14 | If LESS than 1 day, ... hrs. or ..... min.

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) Andrain Co
(STATE OR COUNTRY) Mo

PARENTS

10. NAME OF FATHER John C. Lapsman

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

12. MAIDEN NAME OF MOTHER Polly Kerr

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

14. INFORMANT Ola Blum
(Address) Mexico Mo

15. FILED Feby 1st 1930 Ira S. Milligan REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 30 1930

17. I HEREBY CERTIFY, That I attended deceased from Sept 24, 1929, to Jan 30, 1930 that I last saw b. alive on Jan 29, 1930, and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Nephritis 1 mo

1210 77

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Arteriosclerosis

(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED At home

IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? No. DATE OF .....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) J. F. Flynt, M. D

1-31, 1930 (Address) Paris 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 Mexico Mo Cem

DATE OF BURIAL 2-1 1930

20. UNDERTAKER H A Precht & Son

ADDRESS Mexico Mo

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

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MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.
County: Andrain — Registration District No.: 26 — File No.:
Township: Salt River — Primary Registration District No.: 3034 — Registered No.: 14
City: (No. , St. Ward)

2. FULL NAME: Robert L. Heizer
(a) Residence. No. St. Ward. (If nonresident give city or town and State)
(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
M	W	M

5a. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov-16-1857

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ...min.
	78	1	14	

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)

PARENTS
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. Feby 1st 1930 Ira S Milligan
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 30 1930

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 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:

... (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (SECONDARY) ... (duration) ... yrs. ... mos. ... ds.

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
	19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

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

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

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