

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

Do not use this space.

6682

**1. PLACE OF DEATH**

County..... Registration District No. 791  
 Township..... Primary Registration District No. 1003  
 City St. Louis (No. Mo. Perfect Jan) St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_  
 Registered No. 1505

**2. FULL NAME**

August Heller  
 (a) Residence. No. Rolla Mo St. 12 Ward. Rolla Mo  
 (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 <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Nov 20 1850</u>		
7. AGE	YEARS <u>77</u>	MONTHS <u>2</u>
	DAY <u>21</u>	IF LESS than 1 day, ..... hrs. or ..... min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. <u>Retired Merchant</u> (b) General nature of industry, business, or establishment in which employed (or employer). <u>Clothing</u> (c) Name of employer		

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 11 1930

17. I HEREBY CERTIFY, That I attended deceased from Feb 5 1930, to Feb 11 1930, that I last saw him alive on Feb 11 1930, and that death occurred, on the date stated above, at 2 P m.

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

Carcinoma sigmoid flexure of colon  
 (duration) yrs. mos. ds. 46  
 CONTRIBUTORY (SECONDARY) 45  
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH. Rolla Mo

1 DID AN OPERATION PRECEDE DEATH. Yes DATE OF Jan 8 1930

WAS THERE AN AUTOPSY? Yes Partial

WHAT TEST CONFIRMED DIAGNOSIS? Autopsy  
 (Signed) John C. Mearns M. D.  
Jan 11 1930 (Address) 940 Two B Bldg

\*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.

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

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Robert Heller  
 (Address) Rolla Mo

15. FILED \_\_\_\_\_, 19 \_\_\_\_\_  
Max C. Starkey  
 REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL  
Valhalla Crematory DATE OF BURIAL Feb. 12 1930

20. UNDERTAKER  
H. Rindorff ADDRESS 5216 Delmar

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.

50 10 159

