

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

Do not use this space.

16560

1. PLACE OF DEATH

County Johnson, Registration District No. 431
Township Warrensburg, Primary Registration District No. 3023
City Warrensburg, (No. _____) St. _____ Ward _____

2. FULL NAME

Hiram Calvin Heathco

(a) Residence No. 119 e Gay St. _____ Ward _____
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 11 yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) November 2, 1850

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>79</u>	<u>6</u>	<u>15</u>	<u>15</u>	

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) North Carolina,
10. NAME OF FATHER Nicholas Heathco
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) North Carolina,
12. MAIDEN NAME OF MOTHER Nancy Proctor
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) North Carolina,

14. INFORMANT Mrs Geo Coffman
(Address) Warrensburg, Mo

15. May 23, 1930 Wm R. Allison
FILED _____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May, 17, 1930

17. I HEREBY CERTIFY, That I attended deceased from May 16, 1930 to May 17, 1930 that I last saw him alive on May 17, 1930, and that death occurred, on the date stated above, at 9-30 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

02A
520
97
arterio-sclerosis.
(duration) _____ yrs. _____ mos. 21 ds.
CONTRIBUTORY (SECONDARY) arterio-sclerosis.
(duration) 5 yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? _____
(Signed) A. H. Carter, M. D.
May 19, 1930 (Address) Warrensburg 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 Oak Grove Cem DATE OF BURIAL may, 19, 1930

20. UNDERTAKER S. R. Sweeney, Warrensburg, Mo.
ADDRESS _____

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.

JUL 23 1930
51
6
9

**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 Johnson

Registration District No. 431

File No.

Township

Primary Registration District No. 3023

Registered No.

City Warrensburg

St. Ward)

2. FULL NAME

Hiram Calvin Heathco

(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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S
(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

Mrs. Patterson
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 17 19 30

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:

Paratyphoid
Cerebral Hemorrhage

CONTRIBUTORY (duration) yrs. mos. ds.
ARTERIO SCLEROSIS
(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

N. B.—Every item on this certificate 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

100

100

OUTSIDE

100

S-16560