

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.

19977

1. PLACE OF DEATH

County Livingston
Township Blue mound
City (No.) St. Ward)

Registration District No. 515
Primary Registration District No. 5684

File No.
Registered No. 3

2. FULL NAME

Stephen M. Heckman

(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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan. 23 - 1863

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
67 4 14

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) Iowa

10. NAME OF FATHER John T. Hickman

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

12. MAIDEN NAME OF MOTHER Adeline Querner

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

14. INFORMANT Mrs. Florence M. Austin
(Address) Hawthorn R. 4

15. FILED 6/9, 19 30 Mrs. J. M. Padabough
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 7 1930

17. I HEREBY CERTIFY, That I attended deceased from May 6, 1930, to June 7, 1930 and that I last saw him alive on June 6, 1930 and that death occurred, on the date stated above, at 12:30 A. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Mitral insufficiency
920
113
(duration) 2 yrs. mos. ds.

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

18. WHERE WAS DISEASE CONTACTED
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) S. W. Carpenter, M. D.
6-7-1930 (Address) Utica 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 Blue mound DATE OF BURIAL 6-8-1930

20. UNDERTAKER F. B. Norman ADDRESS Chillicothe Mo.

