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

1 PLACE OF DEATH

County Dallas

Township Washington
or
Village
or
City (NO. , St.; Ward)

Registration District No. 247 File No. 26273

Primary Registration District No. 5342 Registered No. ~~247~~ 14

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME W C Heck

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): married

6 DATE OF BIRTH: Dec 1 (Month) (Day) 1883 (Year)

7 AGE: 47 yrs. 8 mos. 29 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Teamster
(b) General nature of industry business, or establishment in which employed (or employer): Labor

9 BIRTHPLACE (City or town, State or foreign country): Sullivan Indiana

PARENTS
10 NAME OF FATHER: Wm J. Heck
11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Indiana
12 MAIDEN NAME OF MOTHER: unknown
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Indiana

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs W.C. Heck
(Address) Belle Mo

15 Filed Aug 31 1930 J H Balbor Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Aug 30 (Month) (Day) 1930 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Aug 29, 1930, to Aug 30, 1930, that I last saw him alive on Aug 30, 1930, and that death occurred, on the date stated above, at 9.30 P.m.

The CAUSE OF DEATH* was as follows:

Peritonitis

(Duration) 36 hours yrs. mos. ds.

CONTRIBUTORY (Secondary) Ruptured appendix

(Duration) yrs. mos. ds.

(Signed) J H Balbor M. D.

Aug 30, 1930 (Address) Long Lane Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Belle Mo

DATE OF BURIAL: 9-1, 1930

20 UNDERTAKER: J H Moffat, Conway Mo

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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1 PLACE OF DEATH

County .....

Township..... Registration District No..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City..... (NO....., ... St.;.....Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME.....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH

....., 1..... (Month) (Day) (Year)

7 AGE .....yrs.....mos.....ds. | If LESS than 1 day,.....hrs. or.....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE (City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address).....

....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

....., 191..... (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from

....., 191....., to....., 191.....

that I last saw h.....alive on....., 191.....,

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.

(Signed).....M. D.

....., 191..... (Address).....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191.....
20 UNDERTAKER	ADDRESS

Every item of information should be carefully supplied. Age should be stated [illegible] CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.