

NOV 28 1930

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

Do not use this space.

35036

1. PLACE OF DEATH

County Saline  
Township  
City Marshall (No. \_\_\_\_\_)

Registration District No. 796  
Primary Registration District No. 3038

File No. \_\_\_\_\_  
Registered No. 141 St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME

(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 <u>M</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Winnie Heins</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>unknown</u>		
7. AGE YEARS <u>about 80</u>	MONTHS	DAYS
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Ret. Labor</u> (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer		

9. BIRTHPLACE (CITY OR TOWN) Columbus  
(STATE OR COUNTRY) Ohio

10. NAME OF FATHER D. Heins

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

12. MAIDEN NAME OF MOTHER unknown

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

14. INFORMANT Frank Heins  
(Address) 909 Kansas Ave R.C. Kan.

15. FILED 10-22-30 1930 Mrs. Jno. H. McGehee  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from Oct 1 1930 to Oct 17 1930  
that I last saw alive on Oct 17 1930, and that death occurred, on the date stated above, at 2:30 P. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Acute Colitis  
93C.  
1930  
(duration) \_\_\_\_\_ yrs. mos. 10 ds.  
CONTRIBUTORY myocarditis  
(SECONDARY) (duration) several yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH \_\_\_\_\_  
DID AN OPERATION PRECEDE DEATH? No DATE OF \_\_\_\_\_  
WAS THERE AN AUTOPSY? No  
WHAT TEST CONFIRMED DIAGNOSIS \_\_\_\_\_  
(Signed) W. Bone, M. D.  
10-18-30 (Address) Marshall Ind.

\*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 Ridge Park DATE OF BURIAL Oct 19 1930

20. UNDERTAKER L.R. Vardner ADDRESS Marshall Ind.

X. 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.

WHITE PLAIN, WITH UNFADING INK—THIS IS A PERMANENT RECORD

