

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

Do not use this space.

JAN 17 1938

44124

1. PLACE OF DEATH

County Jackson Registration District No. 399
Township Kau Primary Registration District No. 1002
City H. P. Mo. (No. 4233) College

File No. 5027
Registered No. 5027
St. _____ Ward _____

2. FULL NAME

William P. Heskop
(a) Residence, No. 4233 College St. _____ Ward _____
(Usual place of abode)

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 4, 1866

7. AGE YEARS MONTHS DAYS H LESS than 1 day, hrs. or min.
71 2 9

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Printer 55

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Chicago Ill

13. NAME Thomas Heskop

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Scotland

15. MAIDEN NAME Almira Kelley

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ta

17. INFORMANT (ADDRESS) Joe Subbens
4233 College

18. BURIAL, CREMATION, OR REMOVAL PLACE Joplin Mo DATE Dec 14 1937

19. UNDERTAKER (ADDRESS) Mrs. C. L. Forster
918 Broadway av

20. FILED Dec 14 1937 M. M. Brown
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 13 1937

22. I HEREBY CERTIFY, That I attended deceased from _____ 1937, to Dec 13, 1937.
I last saw him alive on Dec 13, 1937. Death is said to have occurred on the date stated above, at 9:30 p.m.

The principal cause of death and related causes of importance were as follows:
Cardiac Insufficiency
Myocardial Degeneration
92a

Date of onset Dec 12 1927

Other contributory causes of importance:
Asthma 1935
Exhaustion of Hot Summer

Name of operation NO Date of _____
What test confirmed diagnosis Chinical Was there an autopsy? NO

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? NO
If so, specify Yes
(Signed) Geodore Anderson, M. D.
(Address) 1317 Rialto Bldg

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.

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Rialto

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