

REC'D APR 7 1938

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

10676
Do not use this space.

1. PLACE OF DEATH

(a) County FRANKLIN 2 Registration District No. 300
(b) Township LYON Primary Registration District No. 5417
(c) City..... (d) Street No..... St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

HERMANN H. HEITHOLD 3 4 3
(a) Residence, No. St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) OCT. 9. 1865

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
72 5 6

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. RETIRED

9. Industry or business in which work was done, as 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) NEW HAVEN Mo

13. NAME HERMANN HEITHOLD

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

15. MAIDEN NAME JOHANA LARKER

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

17. INFORMANT (ADDRESS) Alex Sheer
Wheaton Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE BOEUF DATE MARCH 18 1938

19. FUNERAL DIRECTOR (ADDRESS) A. G. FERTIG, SON
NEW HAVEN Mo

20. FILED 3-18 1938 J. Matthews Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 14, 1938

22. I HEREBY CERTIFY, That I attended deceased from March 7, 1938, to March 14, 1938

I last saw him alive on March 13, 1938. Death is said to have occurred on the date stated above, at 109 m.

The principal cause of death and related causes of importance were as follows:

Pneumonia (senile)

Date of onset 2/28/38

Other contributory causes of importance:

Paratyphoid agilis
Arteriosclerosis

1922

Name of operation none Date of

What test confirmed diagnosis? 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 B. C. Eisenmann, M. D.

(Signed) J. Matthews (Address) Wheaton, Mo.

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.

87/2-

STATEMENT BY LICENSED EMBALMER

I, L. C. Fertig....., Licensed Embalmer No. 2099

hereby certify that the body recorded on the reverse side of this certificate was embalmed by me

..... L. E.

No. or by , Registered Apprentice No.
working under my personal supervision.

Signed L. C. Fertig.....
Licensed Embalmer No. 2099

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

STATE OF OHIO DEPARTMENT OF HEALTH

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

10676
Do not use this space.

1. PLACE OF DEATH

(a) County Franklin Registration District No. 300
(b) Township Lyon Primary Registration District No. 3417 Registered No. 85
(c) City..... (d) Street No..... St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Hermann H. Heithold

(a) Residence, No. St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Wid

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.
72 5 6

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as 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)

FATHER 13. NAME

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

MOTHER 15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 19

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 14, 1938

22. I HEREBY CERTIFY, That I attended deceased from 19... to 19...

I last saw h..... alive on....., 19..... Death is said to have occurred on the date stated above, at.....m.

The principal cause of death and related causes of importance were as follows:

Pneumonia (Senile) Date of onset

Bronchial pneumonia

Other contributory causes of importance: 1072

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

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?.....

If so, specify.....

(Signed) B. P. Eisman, M. D.

(Address) New Haven

