

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.

1939 MAR 13 1939

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS 731  
CERTIFICATE OF DEATH 1008

4854  
Do not use this space.

Registered No. 1547

1. PLACE OF DEATH

(a) County ..... Registration District No. ....  
(b) Township ..... Primary Registration District No. ....  
(c) City St. Louis ..... (d) Street No. City Hospital No. 1 ..... 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 John Heim

(a) Residence, No. 2738 Lafayette St. 23 (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec 6, 1860

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
78 2 9

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Butcher  
9. Industry or business in which work was done, as saw mill, bank, etc. nil  
10. Date deceased last worked at this occupation (month and year) 1923 11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

13. NAME Unknown

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

15. MAIDEN NAME "

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

17. INFORMANT (ADDRESS) Hosp. info M. Kent

18. BURIAL, CREMATION, OR REMOVAL PLACE Zion Cemetery DATE Feb. 17, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Peetz Bros.  
3029 LAFAYETTE AVE.

20. FILED J. B. Budick  
Local Registrar

FEB 17 1939

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2/15/39 19...

22. I HEREBY CERTIFY, That I attended deceased from 1/29/39 to 2/15/39, 19...

I last saw him alive on 2/15/39, 19... Death is said to have occurred on the date stated above, at 4.30 a.m.

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

Acute suppurative nephritis  
Prostatic prostatic  
Other contributory causes of importance: 133a

Name of operation ..... Date of .....  
What test confirmed diagnosis? ..... Was there an autopsy? Yes

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) W. W. Arskew, M. D.  
(Address) City Hospital No. 1

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

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

Signed Francis Owens

Licensed Embalmer No. 2745

P. O. Address.....

**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.)**

**If this body is not embalmed, above space should be left blank.**