DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

SEC'D AUG 11 1939

Registration District No. 791

1003

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No.

State File No. 23723

Registrar's No. 5996

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS shou
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: City Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 days (Specify whether

In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County

(c) City or town St. Louis (If outside city or town limits, write "RURAL") 2

(d) Street No. 6222 Carlsbad (If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME George Lester Heyd

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced S.

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased June (Month) 23 (Day) 1920 (Year)

8. AGE:

Years	Months	Days	If less than one day
19	0	12	hr. min.

9. Birthplace St. Louis (City, town, or county) Mo. (State or foreign country)

10. Usual occupation Delivery boy & clerk

11. Industry or business grocery & meat business

FATHER
12. Name Edward Heyd
13. Birthplace St. Louis (City, town, or county) Mo (State or foreign country)

MOTHER
14. Maiden name Clara Decker
15. Birthplace St. Louis (City, town, or county) Mo (State or foreign country)

16. (a) Informant's own signature Clara Heyd

(b) Address 6222 Carlsbad

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-8-39 (Month) (Day) (Year)

(c) Place: burial or cremation St. Matthews

18. (a) Signature of funeral director Southern Funeral Home

(b) Address 7 7932 S. Grand

19. (a) JUL (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 5th year 1939 hour minute 8:50 p.M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death Acute Toxic Nephritis; Oedema, ascites; Pleurisy with effusion; Acute Myocarditis; due

Due to to acute nephritis cause unknown

Due to 110

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? 4 (Specify type of place)

While at work? (e) Means of injury

23. Signature Joseph [illegible] (M. D. or other)

Address Deputy Coroner Date signed 7/7

(Licensed Embalmer's Statement on Reverse Side)

Coroners Office

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 Virgil L. Berryman

Licensed Embalmer No. 4098

P. O. Address St. Louis Mo.

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

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

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

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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

23723
Do not use this space.

1. PLACE OF DEATH

(a) County ..... Registration District No. 791

(b) Township ..... Primary Registration District No. 1003 Registered No. 5996

(c) City St Louis (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 George Lester (HEYD ?)

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
M	W	S

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.
	19	0	12	

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 9/25/39 J. F. Budick
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-5, 1939

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:

	Date of onset

Other contributory causes of importance:

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) Joseph M. Jim Dey M.D.

(Address) .....

SUPPLEMENTARY