DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 33366

Registration District No. 757 Primary Registration District No. 3036 Registrar's No. 144

1. PLACE OF DEATH:

(a) County St Charles

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

(c) Name of hospital or institution: 813 N. Second Street
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ (Specify whether
In this community ____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State ____ (b) County ____

(c) City or town ____ (If outside city or town limits, write "RURAL")

(d) Street No. ____ (If rural, give location)

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

3. (a) PRINT FULL NAME HENRY HEPPERMAN 115

3. (b) If veteran, name war ____ 3. (c) Social Security No. ____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Elizabeth Heppermann 6. (c) Age of husband or wife if alive ____ years

7. Birth date of deceased September (Month) 20 (Day) 1873 (Year)

8. AGE: Years 66 Months 0 Days 4 If less than one day ____ hr. ____ min.

9. Birthplace Josephville (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Jeweler

11. Industry or business

FATHER
12. Name Godfrey Heppermann
13. Birthplace Unknown (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Vincent Kleeschulte
(b) Address St Charles, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 27-1939 (Month) (Day) (Year)
(c) Place: burial or cremation Paul Brown Cem. Flint Hill, Mo.

18. (a) Signature of funeral director H. C. Dallmeyer & Sons
(b) Address 800 N. Second St. Charles, Mo.

19. (a) 9/25/39 (Date received local registrar) (b) Clarence G. Wessler (Registrar's signature) 67

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9th day 24th year 1939 hour about 12 minute midnight M.

21. I hereby certify that I attended the deceased from Field Inquest to 9/24-39, 19__; that I last saw h__ alive on __, 19__; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Myocardial failure	
Due to Contributory - chronic alcoholism	✓
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations ✓
Of autopsy ✓

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? ____ (Specify type of place)
While at work? ✓ (e) Means of injury ✓

23. Signature John H Burr Coroner ~~(M. D. or other)~~
Address St Charles Co. Mo. Date signed 9/25-39

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
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.
I X19511

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.....

Licensed Embalmer No.....

P. O. Address.....

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

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

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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

33366
Do not use this space.

1. PLACE OF DEATH
(a) County St Charles
(b) Township St Charles
(c) City St Charles
Registration District No. 757
Primary Registration District No. 3036
Registered No. 144
(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 Henry Heppermann
(a) Residence, No. 813 N 2ND ST - ST. CHARLES, MO 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: 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.
66	0	4	

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 NOV 30 1937 Clarence S. Hessler
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9 - 24 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) John H. Bruce, M. D.
(Address) St Charles Mo

SUPPLEMENTARY

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.

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