FILED JUL 1 1940

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

21141

Do not use this space.

1. PLACE OF DEATH
(a) County Bates 3 Registration District No. 53
(b) Township New Home 0 Primary Registration District No. 5084 Registered No. 18
(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 235 Ernest Joe Heckadon
(a) Residence, No. RFD #1 Rich Hill Missouri 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 male
4. COLOR OR RACE white
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) January 20/1928

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
12	3	19	

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. student
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) Bates County 0

FATHER
13. NAME A.J.Heckadon 0
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Bates County Mo. 0

MOTHER
15. MAIDEN NAME Josephine Campbell
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Bates County, Mo.

17. INFORMANT (ADDRESS) A.J.Heckadon Bates County, Mo.

18. BURIAL, CREMATION, OR REMOVAL
PLACE Greenlawn DATE May, 111 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Booth Rich Hill, Missouri 56

20. FILED May 11 1940 Claude J. Allen M.D. R.S. Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May, 9 1940

22. I HEREBY CERTIFY, That I attended deceased from May 9, 1940, to May 9, 1940
I last saw h... alive on May 9, 1940. Death is said to have occurred on the date stated above, at 9 p.m.
The principal cause of death and related causes of importance were as follows:

Fracture of Cervical Vertebrae

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? Accident Date of injury May 9 1940
Where did injury occur? May 9 Home Hall to Mo.
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury Fell from truck & broke neck
Nature of injury Broken neck

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify .....
(Signed) [signature], M. D.
(Address) Rich Hill Mo

(Licensed Embalmer's Statement on Reverse Side)

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.

210m
2

RECEIVED
District Health Officer No. 7,
District File Number 6-40-906
Date Filed 6-19-40

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 John G. Underwood

Licensed Embalmer No. 3585

P. O. Address Butler Missouri

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

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

o. 2B
-21-40
X22659

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 21141

Registration District No. 53 Primary Registration District No. 5084 Registrar's No.

1. PLACE OF DEATH

(a) County Bates

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

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

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

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 Ernest Joe Heckadon

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 (Month) (Day) (Year)

8. AGE: Years 12 Months 3 Days 19 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

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

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 9 year 1940 hour minute M.

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

Immediate cause of death Fracture 2 Cervical Vertebra

Due to Pulmonary Tuberculosis

Due to

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

23. Signature Claude T. Gillen (M.D. or other)
Address Rich Hill Mo Date signed

SUPPLEMENTARY