

Registration District No. **725**

Primary Registration District No. **5956**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Ralls**
(b) City or town **Central Center, Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **2**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **One year**. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Ralls**
(c) City or town **Rural**
(If outside city or town limits, write "RURAL")
(d) Street No. **R.F.D. #2 Center, Mo.**
(If rural, give location)
(e) If foreign born, how long in U. S. A? **60** years.

8. (a) PRINT FULL NAME **Andrew Heide 200**

9. (b) If veteran, name war _____ 3. (c) Social Security No. **None**

4. Sex **Male** 5. Color or race **Caucasian** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Miss Heide** 6. (c) Age of husband or wife if alive **72** years
7. Birth date of deceased **November 22 1863**
(Month) (Day) (Year)

8. AGE: Years **77** ✓ Months **9** Days **12** If less than one day hr. _____ min _____

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

10. Usual occupation **Farmer & Carpenter**

11. Industry or business _____

MOTHER FATHER { 12. Name **Fred Heide**
18. Birthplace **Demark**?
(City, town, or county) (State or foreign country)
14. Maiden name **Christiana (Unknown)**
15. Birthplace **Demark**?
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. E. J. Schuman**

(b) Address **3125 Lafayette Ave., St. Louis, Mo.**

17. (a) **Burial** (b) Date thereof **Sept. 5, 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial **Olivet Cemetery**

18. (a) Signature of funeral director **William C. Couch**
(b) Address **Central, Missouri**

19. (a) **9/13/40** (b) **Edna Heide**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **3**
year **1940** hour _____ minute _____
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 **Death was probably caused from cerebral hemorrhage.**

Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) **87N**

PHYSICIAN
Major findings: Of operations _____
Of autopsy _____
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) **no.**
(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?

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While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature **Clyde C. Wilkey** (M. D. or D. O.)
Address **Perry, Mo. Ralls Co.** Date signed **9/5/40**

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

RECEIVED

District Health Officer No. 10

District File Number 9-40-1833

Date Filed SEP 23 1940

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 Edgar B. Schlenker

Licensed Embalmer No. 4136

P. O. Address Center, Missouri

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.