

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 39927

Registration District No. 820

Primary Registration District No. 6069

Registrar's No. _____

1. PLACE OF DEATH:
 (a) County Scott
 (b) City or town Sylvania Twp Rursh
(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)
 In this community 13 years
years, months or days 2

3. (a) PRINT FULL NAME Frank Lawrence Heisserer
 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, Married
 6. (b) Name of husband or wife Sophia Goetz Heisserer
 6. (c) Age of husband or wife if alive 59 years
 7. Birth date of deceased June 20 1867
(Month) (Day) (Year)

8. AGE: Years 73 Months 5 Days 9
 If less than one day _____ hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business _____
 MOTHER FATHER { 12. Name Simon Heisserer
 13. Birthplace Germany
(City, town, or county) (State or foreign country)
 14. Maiden name Kate Welter
 15. Birthplace Ohio Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs Simon Heisserer
 (b) Address Chaffee Mo

17. (a) Buriah (b) Date thereof Dec. 2 1940
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Guardian Angel Cem Oren Mo

18. (a) Signature of funeral director B. J. Strohoff Hobbar
 (b) Address Chaffee Mo

19. (a) 17 3/40 (b) J. P. Lehman
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County Scott
 (c) City or town Sylvania Twp Rursh
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 29th
 year 1940 hour 2 minute 20 A.M.

21. I hereby certify that I attended the deceased from Aug. 9, 1940 to Nov. 25, 1940
 that I last saw him alive on Nov. 25, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of stomach with metastases

Due to _____
 Due to _____

Other conditions 46
(Include pregnancy within 3 months of death)

Major findings: _____
 Of operations _____
 Of autopsy _____

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?
73 _____
(Specify type of place) (e) Means of injury

23. Signature Edward H. Loest (M. D. or other) P.O.
 Address Oren Mo. Date signed 11-30

Duration _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

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.

RECEIVED

District Health Officer No. 2

District File Number 1240-1776

Date Filed 12/9/40

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 Mamie B. Simpson

Licensed Embalmer No. 3242

P. O. Address Chaffee 7th

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.