

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

FILED SEP 11 1942 149

Registration District No. _____

Primary Registration District No. 1002

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Jackson,

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

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

(d) Length of stay: In hospital or institution 2 1/2 day
(Specify whether years, months or days)

In this community Since 1936,

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri, (b) County Jackson,

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

(d) Street No. 7301 Jarboe,
(If rural, give location)

(e) Citizen of foreign country? no. (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Earl A. Hecker,

3. (b) If veteran, name war NO.

3. (c) Social Security No. 561-16-4552

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 1st
year 1942 hour 12 minute 30 P. M.

21. I hereby certify that I attended the deceased from 9-1-1942 to 9-1-1942

that I last saw him alive on 9-1-1942 and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Juanita Hecker, 6. (c) Age of husband or wife if alive 39 years

7. Birth date of deceased August 20 1886
(Month) (Day) (Year)

Immediate cause of death Pulmonary Edema

Due to Bronchogenic Carcinoma.

Due to 475

Other conditions (Include pregnancy within 3 months of death)

8. AGE:	Years	Months	Days	If less than one day
	<u>56</u>	<u>0</u>	<u>11</u>	hr. _____ min.

Major findings: Of operations _____

Of autopsy above with metastasis to liver

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

10. Usual occupation Air Mail Manager,

11. Industry or business T. W. A., Inc.

MOTHER FATHER { 12. Name George H. Hecker,

13. Birthplace New York, (City, town, or county) (State or foreign country)

14. Maiden name Nellie Burley,

15. Birthplace New York, (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Juanita Hecker,

(b) Address 7301 Jarboe, Kansas City, Mo.

17. (a) removal (b) Date thereof 9-3-42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Jamestown, New York,

18. (a) Signature of funeral director Stine & McClure,

(b) Address 3235 Gillham Plaza, K. C. Mo.

19. (a) 9-3-42 (b) M. M. Grome
(Date received local registrar) (Registrar's signature)

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 A. R. Black (M. D. or other) _____

Address 9221 W. 151st St. KC Mo. Date signed 9-2-42

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

C

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Dr. Don R. Black, Prof. Bldg.,

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 E. M. Plank

Licensed Embalmer No. 1848

P. O. Address W. C. Mo.

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, fact should be so stated above.