No. 2
5-42
17-39
X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILE SEP 1 1942

Registration District No. 42

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 26713

Primary Registration District No. 1000

Registrar's No. 824

1. PLACE OF DEATH:
(a) County: Buchanan
(b) City or town: St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 531 Kentucky St
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: none
In this community: 45 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Buchanan
(c) City or town: St. Joseph
(If outside city or town limits, write "RURAL")
(d) Street No.: 531 Kentucky St
(If rural, give location)
(e) Citizen of foreign country? (Yes or No): No
If yes, name country: 0

3. (a) PRINT FULL NAME: Katherine Edna Heiner

3. (b) If veteran, name war: none

3. (c) Social Security No.: none

4. Sex: Female

5. Color or race: white

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

6. (b) Name of husband or wife: Jesse

6. (c) Age of husband or wife if alive: 44 years

7. Birth date of deceased: December 26, 1896 (Month) (Day) (Year)

8. AGE: Years 45 Months 7 Days 25 If less than one day hr. min.

9. Birthplace: St. Joseph, Mo. (City, town, or county) 0 (State or foreign country)

10. Usual occupation: Housewife

11. Industry or business: home

FATHER
12. Name: James Ballard
13. Birthplace: unknown (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name: Susan McQueen
15. Birthplace: unknown (City, town, or county) 9 (State or foreign country)

16. (a) Informant: Jesse G. Heiner
(b) Address: 531 Kentucky St

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 8-24-42 (Month) (Day) (Year)
(c) Place: burial or cremation: Ashland Cemetery

18. (a) Signature of funeral director: Tracy Barry Funeral
(b) Address: 218 South 10th St

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 21st year 1942 hour 3:30 minute A M.

21. I hereby certify that I attended the deceased from May 18, 1942 to 8-~~20~~ 21, 1942 that I last saw her alive on August ~~19~~ 20, 1942 and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic myocarditis — Duration 3 mo.
Due to: Chronic endocarditis — 3 mo.
Due to: Mitral and aortic valves involved
Due to: Syphilis of heart + aorta — ?
Due to: No history of rheumatic fever, Blood Wassermann 4+
Other conditions (Include pregnancy within 3 months of death):

Major findings:
Of operations: none
Of autopsy: none made

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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: E. E. Grant M.D. (M. D. or other)
Address: St. Joseph, Mo. Date signed: 8-22-42

133 (Licensed Embalmer's Statement on Reverse Side)

SEP 6

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 Victor J. Barry

Licensed Embalmer No. 4212

P. O. Address St Joseph 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.

. S. No. 2B
DM—8-21-41
I X29288

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. 26713

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 824

1. PLACE OF DEATH:

(a) County: Buchanan

(b) City or town: St Joseph
(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: 45 yrs.

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) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME: Katherine Edna Heiner

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex: F

5. Color or race: W

6. (a) Single, widowed, married, divorced: M

6. (b) Name of husband or wife: Jesse Lee

6. (c) Age of husband or wife if alive: 44 years

7. Birth date of deceased: (Month) Dec (Day) 26 (Year) 1896

8. AGE: Years 45 Months 7 Days If less than one day hr. min.

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

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) 8-24-42 (Date received local registrar) (b) Rose Herzog. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 26 year 1942 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19;

that I last saw h alive on 19;

and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Due to	
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 (M. D. or other)

Address Date signed

SUPPLEMENTARY