

S. No. 2
M-5-42
5-17-39
PI X32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32025

FILED OCT 28 1942
318

State File No.

Registration District No.

Primary Registration District No. 1003

Registrar's No. 8589

1. PLACE OF DEATH:
(a) County
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
4536 Holly Ave. /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
(Specify whether
In this community Life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County.....
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 4536 Holly Ave.
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Clara A. Heidbrink
(b) If veteran. name war No
3. (c) Social Security No. None

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month October day 14th,
year 1942 hour 10:30 minute 4 M.
21. I hereby certify that I attended the deceased from 9-15-40
....., 19....., to 10-14-42, 19.....
that I last saw her alive on 10-13-42, 19.....;
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
(b) Name of husband or wife Harman Heidbrink
6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased September 27th, 1858
(Month) (Day) (Year)

Immediate cause of death
Carcinoma of Liver. 2 yrs.

8. AGE: Years Months Days If less than one day
84 0 17 hr. min.

Due to Cardiac Thrombosis. 1 hr

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

Due to

10. Usual occupation Housework

Other conditions (Include pregnancy within 3 months of death)

11. Industry or business

Major findings: Of operations.....
Of autopsy.....

MOTHER FATHER { 12. Name Charles Naber

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

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

14. Maiden name Unknown

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

16. (a) Informant
(b) Address.....

17. (a) Burial (b) Date thereof Oct. 17, 1942.
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Peters Cemetery

18. (a) Signature of funeral director Calvin F. Feutz Funeral H
(b) Address 4828 Natural Bridge

19. (a) Oct 16 1942 (b) J. F. Budeck
(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.....
Signature Les A. Melles (M. D. or other)
Address 2739 N. Grand Date signed 10-15-42

(Licensed Embalmer's Statement on Reverse Side)

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

W. V.
Grand St. Louis

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.....

John A. Mlinar....., Registered Apprentice No.....
working under my personal supervision.

Signed *John A. Mlinar*.....

Licensed Embalmer No. *4186*

P. O. Address *St. Louis 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 32025
Registrar's No. 85-89

Registration District No. 318

Primary Registration District No. 1003

1. PLACE OF DEATH:

- (a) County.....
- (b) City or town St Louis
(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.....
years, months or days)

- 3. (a) PRINT FULL NAME Clara H. Heidbrink
- 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 W
- 6. (b) Name of husband or wife.....
- 6. (c) Age of husband or wife if alive..... years
- 7. Birth date of deceased Sept 27
(Month) (Day) (Year)

- 8. AGE: Years 84 Months 0 Days no
If less than one day min.

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

- 10. Usual occupation.....

- 11. Industry or business.....

- 12. Name.....
- 13. Birthplace.....
(City, town, or county) (State or foreign country)
- 14. Maiden name.....
- 15. Birthplace.....
(City, town, or county) (State or foreign country)

- 16. (a) Informant Wm Ed Weiss
- (b) Address 4536 Holly Ave

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

- 18. (c) Signature of funeral director.....

- (b) Address.....
- 19. (a) NOV 27 1942 (b) J. F. Bredeek
(Date received local registrar) (Registrar's signature)

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.....

MEDICAL CERTIFICATION

- 20. DATE OF DEATH: Month Oct Day 27 year 1942 hour..... minute..... M.
- 21. I hereby certify that I attended the deceased from..... 19.....
that I first saw him..... 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..... <small>(Include pregnancy within 3 months of death)</small>	
Major findings: Of operations.....	PHYSICIAN Underline the cause to which death should be charged statistically.
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)
 - (b) Did injury occur in or about home, on farm, in industrial place, in public place?

(Specify type of place)
 - While at work?..... (c) Means of injury.....

- 23. Signature..... (M. D. or other).....
Address..... Date signed.....

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

SUPPLEMENTARY

MOTHER FATHER

