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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

15150

State File No. \_\_\_\_\_

APR 16 1943 291

Registration District No. \_\_\_\_\_

Primary Registration District No. 4455

Registrar's No. 26

1. PLACE OF DEATH:

(a) County PUTNAM  
(b) City or town UNIONVILLE  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
MONROE HOSPITAL & CLINIC - 2nd  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2 hrs.  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County PUTNAM  
(c) City or town RURAL  
(If outside city or town limits, write "RURAL")  
(d) Street No. POWERSVILLE, MO.  
(If rural, give location)  
(e) Citizen of foreign country? ✓ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME ALEC E KAY HEINEMAN

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 S, O  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased 3 29 1941  
(Month) (Day) (Year)

8. AGE: Years 1 Months 11 Days 2 If less than one day: \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) MO. O (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name RONALD K. HEINEMAN  
13. Birthplace S. D.  
14. Maiden name GLADYS KLINGEMIS MITCH  
15. Birthplace IOWA

16. (a) Informant Robert Keith Heineman

(b) Address Lucerne, Miss

17. (a) Burial (b) Date thereof March 24  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lucerne, MO

18. (a) Signature of funeral director Wm. W. ...

(b) Address Unionville, MO.  
19. (a) 3/10/43 (b) ...  
(Date received local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 1  
year 1943 hour 2:30 minute \_\_\_\_\_ A.M.  
21. I hereby certify that I attended the deceased from March 1  
1943 to March 1 1943  
that I last saw her alive on March 1 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Acetylsalicylic acid poisoning  
Due to Self administered by three year old child  
Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

Duration  
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) 086 ✓  
(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 L. W. McDougle (M. D. or other) 100  
Address Powersville, MO. Date signed 3/2/43

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

MOTHER FATHER

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.....

RECEIVED  
working under my personal supervision.

District Health Officer No. 10

District File Number 4-43-753

Date Filed APR 15 1943

Signed

*J. O. Hurst*

Licensed Embalmer No. 2975

P. O. Address Unionville

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. 15-150

Registration District No. 291

Primary Registration District No. 4433

Registrar's No. 26

1. PLACE OF DEATH:

(a) County Pulnam  
 (b) City or town Unionville  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Monroe Haas Clinic  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 2 hrs (Specify whether  
 In this community 2 hrs  
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Pulnam  
 (c) City or town Rural  
 (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 Alice K Heineman

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced 3

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased (Month) (Day) (Year)

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

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

10. Usual occupation

11. Industry of business

MOTHER FATHER

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 \_\_\_\_\_ (b) Address \_\_\_\_\_

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

18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb Day 19 Year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
 21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_  
 that I have seen him/her live on \_\_\_\_\_ 19\_\_\_\_  
 and that death occurred on the date and hour stated above.  
 Immediate cause of death \_\_\_\_\_

Due to Acetylsalicylic acid poisoning  
self administered by 3 yr old child  
 Due to \_\_\_\_\_  
 Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
 179X  
 13

Duration \_\_\_\_\_  
 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, ~~ADULT SUICIDE~~ (specify) Accident  
 (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 L. W. Donald (M. D. or other) D.O.  
 Address Bowersville Date signed 2/19/43

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

SUPPLEMENTARY

S-15150