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I. X29484

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 6 1943

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 37790

Registration District No. 42 | Primary Registration District No. 1000 | Registrar's No. 1253

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: State Mental Hos. (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 24 days (Specify whether years, months or days)
In this community: Same

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: Jackson
(c) City or town: Independence (If outside city or town limits, write "RURAL")
(d) Street No.: 123 West College (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country: —

3. (a) PRINT FULL NAME: Ruth B. Heldman
3. (b) If veteran, name war: No
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: Al Heldman
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: 3 (Month) 2 (Day) 1892 (Year)
8. AGE: Years 51 Months 9 Days 8 If less than one day hr. min.
9. Birthplace: Carrol Co (City, town, or county) Mo. (State or foreign country)
10. Usual occupation: Housewife
11. Industry or business: —
FATHER 12. Name: John H Gray
FATHER 13. Birthplace: Carrol Co (City, town, or county) Mo. (State or foreign country)
MOTHER 14. Maiden name: Ida J. Hardwick
MOTHER 15. Birthplace: Carrol Co (City, town, or county) Mo. (State or foreign country)
16. (a) Informant: Records
(b) Address: State Hospital
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Nov 10 (Month) 43 (Day) (Year)
(c) Place: burial or cremation: Independence Mo.
18. (a) Signature of funeral director: Geo. C. Carson
(b) Address: Independence, Mo
19. (a) Nov. 12, 1943 (Date received local registrar) (b) Rob Heizer (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 10 year 1943 hour 1 30 minute P M.
21. I hereby certify that I attended the deceased from 10/12, 1943 to 11/10/43, 19..; that I last saw her alive on 11/10/43, 19..; and that death occurred on the date and hour stated above.

Immediate cause of death: Hypertensive Encephalopathy
Due to: Syphilis 20 Y
Due to: —
Other conditions: Nephritis Encephalitis
(Include pregnancy within 3 months of death)
Major findings: Syphilitic
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): No
(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: L. A. Duchaine M.D. (M. D. or Other)
Address: State Hosp #3 St Joseph, Mo Date signed: 11/11/43

1283

(Licensed Embalmer's Statement on Reverse Side)

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

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. Dean Owens

Licensed Embalmer No. 4280

P. O. Address. Independence, 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.