

FILED APR 12 1944

Registration District No. 70

Primary Registration District No. 5280

Registrar's No. 29

1. PLACE OF DEATH:

(a) County Clark
(b) City or town Rural Lincoln Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Clark 23
(c) City or town Rural Lincoln Twp
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Ada S. Heinberg

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

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

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

7. Birth date of deceased March 25 1881
(Month) (Day) (Year)

8. AGE: Years 62 Months 11 Days 20 If less than one day _____ hr. _____ min.

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

10. Usual occupation at home

MOTHER FATHER

11. Industry or business _____

12. Name Henry Heinberg

13. Birthplace Bondary 4
(City, town, or county) (State or foreign country)

14. Maiden name Anna Decker

15. Birthplace Sowa 1
(City, town, or county) (State or foreign country)

16. (a) Informant Alta Heinberg

(b) Address Kahoka Mo R.F.D

17. (a) Burial (b) Date thereof 3-17-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ashton Cemetery

18. (a) Signature of funeral director Fred Karla

(b) Address Kahoka Mo

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 15 day March
year 1944 hour 4 minute 30 A.M.

21. I hereby certify that I attended the deceased from Mar 15
1944 to Mar 15 1944
that I last saw him no alive on 3/15
and that death occurred on the date and hour stated above.

Immediate cause of death Apoplexy

Due to Accidents +

Due to Apoplexy

Other conditions 83a!
(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) _____

(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? no (Specify type of place) (b) Means of injury no

23. Signature J.P. [unclear] (M. D. or other) _____

Address Kahoka Mo Date signed _____

WRITE PLAINLY—USE UNFADING INK

APR 18 1944

RECEIVED

District Health Officer No. 10

District File Number

Date Filed

4-44-720
APR 8 1944

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.....

Licensed Embalmer No. 1023

P. O. Address. Kahoka Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

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

1. PLACE OF DEATH:

(a) County Clark
(b) City or town Rural Lincoln Twp
(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

Ada S. Heinberg

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.

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

7. Birth date of deceased Mar. 25 (Month) (Day) (Year)

8. AGE: Years 62 Months 11 Days _____ 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 _____
(b) Address _____
17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____
19. (a) 4-5-44 (b) Perry S. Borton
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
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 March year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him/her 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? _____
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

APK

10692