

8-43
17-39
X37823

FILED NOV 30 1944

Registration District No.

Primary Registration District No.

Registrar's No.

186

1. PLACE OF DEATH:

(a) County St. Francois
(b) City or town Farmington, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
State Hospital # 4
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 month 13 days
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 3608 Connecticut
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 3,
year 1944 hour 11 minute 45 A. M.
21. I hereby certify that I attended the deceased from
August 20, 1944 19. to October 3, 1944 19. ;
that I last saw him alive on October 3, 1944 19. ;
and that death occurred on the date and hour stated above.

3. (a) PRINT FULL NAME Henry Heil Jr.
3. (b) If veteran, name war _____ 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Divorced

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

7. Birth date of deceased August 14, 1897
(Month) (Day) (Year)

8. AGE: Years 47 Months 1 Days 19 If less than one day
hr. _____ min. _____

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

10. Usual occupation None

11. Industry or business _____

12. Name Henry Heil

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

14. Maiden name Adele Rupprecht

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

16. (a) Informant M.F. Braun
(b) Address Broadway & Chippewa

17. (a) Cremation (b) Date thereof 10/4/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Missouri Crematory

18. (e) Signature of funeral director Wm. J. Robert L. & U. Co.

(b) Address 1905 S. Grand - St. Louis

19. (a) Oct 15 1944 (b) John H. Johnson
(Date received local registrar) (Registrar's signature)

Immediate cause of death Cerebral apoplexy Duration _____

Due to _____

Due to _____

Other conditions Cerebral aneurysm of left ventricle
(Include pregnancy within 3 months of death) humbly

Major findings: Of operations _____

Of autopsy No 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)

(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 W. J. Robert L. & U. Co. (M. D. or other) Wm. J. Robert L. & U. Co.
Address 408 W. Fifth Date signed 10-10-44

PHYSICIAN

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Underline the cause to which death should be charged statistically.

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

MOTHER, FATHER

1373

RECEIVED

District Health Officer No. 4
District File Number 1144-4469
Date Filed 11-3-44

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. 3114

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Nov.
Registrar's No.

Registration District No. 376 Primary Registration District No. 6075

1. PLACE OF DEATH:

(a) County St. Francis
(b) City or town Jacksonport Union Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hospital #4
(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 Henry Heil Jr.
3. (b) If veteran, name war. _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced. 2
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased Aug 14 1897
(Month) (Day) (Year)

8. AGE: Years 47 Months 1 Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or 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)

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 _____ Day _____ Year _____ Hour _____ Minute _____ M.
21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____;
that I last saw him _____ alive on _____ 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____
Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____
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)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? _____ (Specify type of place) (c) Means of injury _____

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

SUPPLEMENTARY

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

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 35164Registration District No. 376Primary Registration District No. 6075-

Registrar's No. _____

1. PLACE OF DEATH:

(a) County St. Francois
(b) City or town Farmington
(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 days3. (a) PRINT
FULL NAME Henry Deel, Jr.3. (b) If veteran, _____ 3. (c) Social Security
name war _____ No. _____4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced 26. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
alive _____ years7. Birth date of deceased Aug 14 1884
(Month) (Day) (Year)8. AGE: Years 47 Months 1 Days _____ (Unless otherwise days)
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 _____
(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)

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 9 year 1944 minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____;

that I last saw him alive on _____, 19____;

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

Immediate cause of death Cerebral Apoplexy and Duration _____
terminal pneumonia
not specifiedDue to C. N. S. Les

Due to _____

Due to _____

Other conditions Fracture of Humerus
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline
the cause to
which death
should be
charged sta-
tistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Fall out of bed(b) Date of occurrence 9-27-44(c) Where did injury occur? Farmington, St. Francois, Mo.
(City or town) (County) (State)(d) Did injury occur in or about home, on farm, in industrial place, in public place?
On the ward of State Hospital No. 4While at work? No (Specify type of place) (c) Means of injury A fall.23. Signature St. Louis (M. D. or other) mdAddress Little Rock, Mo. 4 Date signed 1-15-45

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

SUPPLEMENTARY