

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: General Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. unknown 8 days
(Specify whether years, months or days)

In this community 44 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson, 48

(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")

(d) Street No. 1509 Fremont
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No) 1

If yes, name country X

3. (a) PRINT FULL NAME Rolla David Heckman

3. (b) If veteran, name war X no

3. (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 18th
year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from 8:44, Dec., 1944, to Dec. 18, 1944.

4. Sex Male 0 5. Color or race White

6. (a) Single, widowed, married, divorced. Single

6. (b) Name of husband or wife X

6. (c) Age of husband or wife if alive. X years

7. Birth date of deceased October 3 1882
(Month) (Day) (Year)

that I last saw h _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

8. AGE:	Years	Months	Days	If less than one day
	<u>62</u>	<u>2</u>	<u>15</u>	_____ hr. _____ min.

Acute circulatory failure.

Due to Fatal hemorrhage

9. Birthplace Kansas 1
(City, town, or county) (State or foreign country)

10. Usual occupation at home

Due to Allergic Purpura hemorrhagica (Schönlein & Knock Type)

Other conditions (Schönlein & Knock Type)
(Include pregnancy within 3 months of death)

11. Industry or business _____

12. Name William Heckman

13. Birthplace Pennsylvania 1
(City, town, or county) (State or foreign country)

14. Maiden name Mary Allsup

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

Major findings: 72 a.

Of operations _____

Of autopsy See Above

16. (a) Informant Mrs. Lottie Ashby

(b) Address 2918 Tracy, Kansas City, Missouri

17. (a) Removal (b) Date thereof 12-20-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Coffeyville, Kansas

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? _____

18. (a) Signature of funeral director Stine & McClure

(b) Address 3235 Gillham Plaza, Kansas City, Mo.

19. (a) 12-19-44 (b) N. E. Brown
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)

(c) Means of injury _____

23. Signature A. E. Walker (M. D. or other) MD
Address General Hospital Date 12/19/44

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.....
working under my personal supervision.

Signed E. M. Black

Licensed Embalmer No. 1848

P. O. Address K. C. Ma

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.