

#38843
FILED MAR 31 1945

Registration District No. **318** Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County.....

(b) City or town..... **St. Louis, Mo.**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **Memorial St. Louis City Hospital - 921 North 10th St.**
(If not in hospital or institution, write street number of location)

(d) Length of stay: In hospital or institution **3 Days** (Specify whether years, months or days)

In this community.....
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County.....

(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")

(d) Street No. **3934 Russell**
(If rural, give location)

(e) Citizen of foreign country?..... (Yes or No) **0**
If yes, name country.....

3. (a) PRINT FULL NAME **Jackson Heiss**

3. (b) If veteran, name war..... **none**

3. (c) Social Security No. **none**

4. Sex **male** 5. Color or race **White**

6. (a) Single, widowed, married, divorced..... **1**

6. (b) Name of husband or wife **Dora Clark Heiss**

6. (c) Age of husband or wife if alive **abt. 75** years

7. Birth date of deceased **Sept. 27 1888**
(Month) (Day) (Year)

8. AGE: **86** Years Months **4** Days **17** If less than one day hr. min.

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

10. Usual occupation **Carpenter**

11. Industry or business.....

MOTHER FATHER { 12. Name **Rudolph Heiss**

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

14. Maiden name **Dont know**

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

16. (a) Informant **Dora Heiss**
(b) Address **3924 Russell**

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

(c) Place: burial or cremation **Springfield Ill.**

18. (a) Signature of funeral director **Jos. J. Ryan**
(b) Address **1519 S. Grand Blvd**

19. (a) **FEB 14 1945** (b) **J. F. Bredebeck**
(Date recorded and certified) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **February** day **14** year **1945** hour **7:00** minute **4** A. M.

21. I hereby certify that I attended the deceased from **February February 12, 1945** to **February 14, 1945** that I last saw him alive on **February 14, 1945** and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral hemorrhage** Duration.....

Due to **general arterio sclerosis**

Due to.....

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

PHYSICIAN

Major findings: Of operations.....

Of autopsy.....

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)

(c) Means of injury **0**

23. Signature **Sw. G. G. G.** (M. D. or D. O.)
Address **1515 1/2 St.** Date signed **2/14/45**

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..... *Alex Campbell*
Licensed Embalmer No..... *3881*
P. O. Address..... *4355 Washu*

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.

Registration District No. 318

Primary Registration District No. 003

Registrar's No. 1481

1. PLACE OF DEATH:

(a) County.....
(b) City or town St Louis, Mo
(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 Jackson Heris

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 Married

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

7. Birth date of deceased Sept 27 (Month) (Day) (Year)

8. AGE: Years 86 Months 4 Days..... If less than one day min. 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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation.....

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

(b) Address.....

19. (a) (Date received local registrar) (b) J. F. Brudeck (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 Feb year, 1945 hour..... minute..... M.

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

that I last saw h..... 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

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

2B
13
36130

4344