

No. 2
-8-43
5-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **27113**
Registrar's No. **53**

FILED AUG 21 1945
Registration District No. **10**

Primary Registration District No. **5280**

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

1. PLACE OF DEATH:
(a) County **Clark**
(b) City or town **Medill**
(c) Name of hospital or institution: **Lincoln Hosp.**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Pa.** (b) County **Lebanon**
(c) City or town **Lebanon**
(If outside city or town limits, write "RURAL")
(d) Street No. **230 S 17th St**
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No) _____
If yes, name country _____

3. (a) PRINT FULL NAME **Chester B Heagy**
3. (b) If veteran, name war **II**
3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **July** day **20th** year **1945** hour **4:39** minute **2** M.
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

4. Sex **Male** 5. Color or race **W.** 6. (a) Single, widowed, married, divorced **9**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Jan 6 1912**
(Month) (Day) (Year)

that I last saw him 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
33 6 14 hr. min.

Crushed Skull
Duration _____

9. Birthplace **Lebanon Pa**
(City, town, or county) (State or foreign country)
10. Usual occupation **Soldier US Army**

Due to **falling from trestle at medill Santa Fe train**

11. Industry or business _____
12. Name **Harry H. Heagy**
13. Birthplace **Lebanon Pa**
(City, town, or county) (State or foreign country)
14. Maiden name **Emma Brightbill**
15. Birthplace **Lebanon Pa**
(City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant **Lebanon (Pa.) Red Cross**
(b) Address **Lebanon, Pa.**
17. (a) **removal** (b) Date thereof **7-23-45**
(Burial, cremation, or removal) (Month) (Day) (Year)

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? _____

(c) Place: burial or cremation **Lebanon Pa Grad Charles**
18. (a) Signature of funeral director **Kathleen**
(b) Address _____
19. (a) **8-1-45** (b) **Perry S. Boston**
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place) (c) Means of injury _____
23. Signature **Perry S. Boston** (M. D. or other) _____
Address **Raheok, Mo** Date signed **7-21-45**

FEB 15 1950

JUL 28 1945

DEC 13 1945

FEB 2 1950

RECEIVED

District Health Officer No. 10

District File Number 8-45-1353

Date Filed AUG 20 1945

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 Fred J Karas

Licensed Embalmer No. 1023

P. O. Address Kalota Wyo

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. Sept
Registrar's No. 53

Registration District No. 10

Primary Registration District No. 5280

1. PLACE OF DEATH:

(a) County Clark
(b) City or town Lincoln Jung Meadell
(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

Chester B. Heagy
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 _____
6. (b) Name of husband or wife unknown 6. (c) Age of husband or wife _____
7. Birth date of deceased Jan 6 (Month) (Day) (Year)

8. AGE: Years 33 Months _____ Days _____ If less than one day _____ hr. _____ 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 _____ (Month) (Day) (Year)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____
19. (a) 5/24-45 (Date received local registrar) (b) J.R. Bridges M.D. (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 _____ 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 _____

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) Accident
(b) Date of occurrence 7-20-1945
(c) Where did injury occur? Midvale Clark Mo. (City or town) (County) (State)
(d) Did injury occur in or about home, or farm, in industrial place, in public place? R.R. Crossing

While at work: Riding train (Specify type of place or means of injury)

23. Signature J.S. Barton Coroner (M.D. or other) _____
Address Wahaha Mo Date signed _____

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

SUPPLEMENTARY

S-27113

DEC 13 1965