. No. 2
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5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

34080

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED NOV 8 1945

State File No. .....

Registration District No. 171 Primary Registration District No. 4268 Registrar's No. 49

1. PLACE OF DEATH:

(a) County LAFAYETTE

(b) City or town MAYVIEW, MO
(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 44 YEARS
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County LAFAYETTE 54

(c) City or town MAYVIEW, MO
(If outside city or town limits, write "RURAL") 0

(d) Street No. 0
(If rural, give location)

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

If yes, name country .....

3. (a) PRINT FULL NAME LOUISE C. HEIDBRINK

3. (b) If veteran, name war NO

3. (c) Social Security No. NO

4. Sex FEMALE 1

5. Color or race WHITE

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

6. (b) Name of husband or wife W. J. HEIDBRINK

6. (c) Age of husband or wife if alive 64 years

7. Birth date of deceased MAY (Month) 6 (Day) 1882 (Year)

8. AGE:

Years	Months	Days	If less than one day
63	4	24	..... hr. ..... min.

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

10. Usual occupation HOUSEWIFE

11. Industry or business .....

FATHER
12. Name GEORGE C. ALTMANSBERGER
13. Birthplace OKAWVILLE ILL 1
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name MARY WINDMILLER
15. Birthplace ST. LOUIS MO 0
(City, town, or county) (State or foreign country)

16. (a) Informant W. J. HEIDBRING

(b) Address MAYVIEW MO

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof NOV 1 1945 (Month) (Day) (Year)

(c) Place: burial or cremation HIGGINSVILLE CITY CEMETERY

18. (a) Signature of funeral director E. S. JAMES

(b) Address CONCORDIA MO

19. (a) Oct. 31 (Date received local registrar) (b) Lotta Drummond (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCTOBER day 29
year 1945 hour 8 minute P M.

21. I hereby certify that I attended the deceased from Oct 26, 1945 to Oct 29, 1945;
that I last saw h..... alive on ....., 19....;
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage, Duration 4 days

Due to Hypertension & arteriosclerosis

Due to .....

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

Major findings:
Of operations .....
Of autopsy .....

83W

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? .....
(Specify type of place)

While at work? ..... (e) Means of injury .....

23. Signature R. C. Schroeder (M. D. or other)

Address Odessa Mo Date signed 10/31/45

15(0)

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number .....
Date Filed 11-6-45

NOV 19 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 me

....., Registered Apprentice No. .....,

working under my personal supervision.

Signed E. S. James

Licensed Embalmer No. 2058

P. O. Address Bonnots Mill 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.