

STANDARD CERTIFICATE OF DEATH

State File No. 9642

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

1. PLACE OF DEATH:

(a) County St. Louis Mo

(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: Lewis and Clark Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 weeks  
(Specify whether In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St. Louis

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

(d) Street No. 9984 Manchester  
(If rural, give location)

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

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME William R. Heggimbrochan

3. (b) If veteran, ✓ name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION:

20. DATE OF DEATH: Month Nov day 5th year 1945 hour 1:30 minute \_\_\_\_\_ A. M.

21. I hereby certify that I attended the deceased from Sept 29 1944 to Nov 5 1945

that I last saw him alive on Nov 4 1945 and that death occurred on the date and hour stated above.

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, 1 divorced married

6. (b) Name of husband or wife Vera Heggimbrochan 6. (c) Age of husband or wife if alive 52 years

7. Birth date of deceased Sept 5 1883  
(Month) (Day) (Year)

Immediate cause of death: Acute Pulmonary Edema at intervals until Nov 5th/45 Duration 10-22/45

Due to Left Ventricular Decompensation 3rd degree heart block

Due to \_\_\_\_\_

8. AGE: Years 62 Months 2 Days 0 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Caretaker

11. Industry or business Rose Bowl Tourist Camp

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Mrs Heggimbrochan

(b) Address 9984 Manchester

17. (a) burial (b) Date thereof 11-9-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Matthews

18. (a) Signature of funeral director M. S. Cargham

(b) Address 7146 Manchester

19. (a) NOV 7 1945 (Date of local registrar) J. F. Bredeek (Registrar's signature)

Other conditions Jaundice (mild)  
(Include pregnancy within 3 months of death)

Major findings: None

Of operations None

Of autopsy None

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 J. F. Bredeek (M. D. or other) MD  
Address 221 N. Milwood Rd Date signed 11-6-45

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

1079

St. Louis, Mo

**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.....

*W. W. Wilkins*

Licensed Embalmer No. 3575

P. O. Address.....

**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.**