V. S. No. 2
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Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 6 1945

THE STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

36210

State File No.

Registration District No. 147 Primary Registration District No. 1002 Registrar's No. 4755

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

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution St Joseph Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 9 days (Specify whether
In this community 45 yrs years, months or days)

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. 221 So Lawn 8
(If rural, give location)
(e) Citizen of foreign country? (Yes or No) N
If yes, name country

3. (a) PRINT FULL NAME Lee Louise Heivner Heivner
3. (b) If veteran, name war no
3. (c) Social Security No. no
4. Sex Fe
5. Color or race W
6. (a) Single, widowed, married, divorced Wid
6. (b) Name of husband or wife Frank Heivner
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Feb 9 1874 (Month) (Day) (Year)
8. AGE: Years 71 74 Months 9 9 Days If less than one day hr. min.
9. Birthplace (City, town, or county) Sweden (State or foreign country)
10. Usual occupation at home
11. Industry or business
FATHER 12. Name John P. Thorsell
13. Birthplace (City, town, or county) Sweden (State or foreign country)
MOTHER 14. Maiden name Josephine Ossan
15. Birthplace (City, town, or county) Sweden (State or foreign country)
16. (a) Informant Mrs Thos Pratt
(b) Address 321 So Lawn
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 21-1945 (Month) (Day) (Year)
(c) Place: burial or cremation Mt Moriah
18. (a) Signature of funeral director Mrs C. R. Fenter
(b) Address 918 Brooklyn
19. (a) 11-20-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 18 year 1945 hour 4 minute 15P M.
21. I hereby certify that I attended the deceased from Nov 9 1945, to Nov 18, 19; that I last saw h alive on 19; and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death Fracture of Left Hip | 9 days |
| Due to Hypertension Heart | 2 yrs |
| Due to Hypertension | 3 yrs |
| Other conditions (Include pregnancy within 3 months of death) | |

Major findings:
Of operations 1860 x 5 18
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) Fall in home 123
(b) Date of occurrence Nov 9-45 approx 4 p
(c) Where did injury occur? Kc (City or town) Jack Co (County) Mo (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home (Specify type of place)
While at work? (e) Means of injury While getting out of bed
23. Signature R L Stevens (M. D. or other)
Address 5242 St Louis Date signed 11-18-45

(Licensed Embalmer's Statement on Reverse Side)

07.4.2 - Cheap -
5242 St John - Be 0141
101 So Ramm Be 0423
2 to 5 Pm

## 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 Cortland Minor

Licensed Embalmer No. 3414

P. O. Address 918 Brooklyn

**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.**