

FILED JAN 3 1948
 Registration District No. 219

Primary Registration District No. 6469

State File No.

Registrar's No.

1. PLACE OF DEATH:

(a) County STE. GENEVIEVE

(b) City or town STE. GENEVIEVE
(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
years, months or days)

In this community _____
years, months or days)

3. (a) PRINT

FULL NAME CONWAY J. HEOB

3. (b) If veteran, name war _____ 3. (c) Social Security No. 493-30-7013

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced SINGLE

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

7. Birth date of deceased: JAN 1 1930
(Month) (Day) (Year)

8. AGE: Years 15 Months 11 Days 24 If less than one day
hr. _____ min.

9. Birthplace CRYSTAL CITY MO
(City, town, or county) (State or foreign country)

10. Usual occupation SCHOLAR

11. Industry or business _____

 MOTHER FATHER { 12. Name ALFRED E. HEOB

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

 14. Maiden name MARGARET SCHUTTE

 15. Birthplace RICHWOODS MO
(City, town, or county) (State or foreign country)
16. (a) Informant Alfred E. Heob
 (b) Address St. Genevieve Mo

 17. (a) BURIAL (b) Date thereof 12-27-45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation St. Genevieve Mo
 18. (a) Signature of funeral director Doc. Baker

 (b) Address St. Genevieve Mo

 19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County STE. GENEVIEVE 95

(c) City or town STE. GENEVIEVE 1
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location) 1

(e) Citizen of foreign country? NO (Yes or No) 0

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month DEC day 25
year 1945 hour 8 minute 20 A.M.

21. I hereby certify that I attended the deceased from Dec 18
1945 to Dec 25 1945
that I last saw him alive on Dec 24 1945
and that death occurred on the date and hour stated above.

Immediate cause of death

Double lobar Pneumonia
(Virus Type)

Duration

one week

Due to _____

Due to _____

 Other conditions
(Include pregnancy within 3 months of death)

Major findings:

Of operations 100

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 Arthur E. Begonia (M. D. or other) M.D.
Address St. Genevieve Mo Date signed 12-27-45

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..... *Les C. Baxter*

Licensed Embalmer No. *1925*

P. O. Address *St. Simons Is.*

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.

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3-45
K43880

State File No. Jan 8
Registrar's No. 8

Registration District No. 319

Primary Registration District No. 4469

1. PLACE OF DEATH:

(a) County St. Genevieve
(b) City or town St. Genevieve
(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..... (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Census J Heat

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

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

8. AGE: Years 15 Months 4 Days 1 If less than one day..... hr. min.

9. Birthplace Hospital City (City, town, or county) (State or foreign country) MO

10. Usual occupation Student

11. Industry or business.....

12. Name Alfred Hark

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

14. Maiden name Margaret Schutte

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

16. (a) Informant Alfred Hark
(b) Address St. Genevieve, MO

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/27/48 (Month) (Day) (Year)

(c) Place: burial or cremation St. Genevieve, MO

18. (a) Signature of funeral director Leo C. Oakes
(b) Address St. Genevieve, MO
19. (a) 1/31/46 (Date received local registrar) (b) Leo Oakes (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 Dec Day 5 Year 1948 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.....

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:

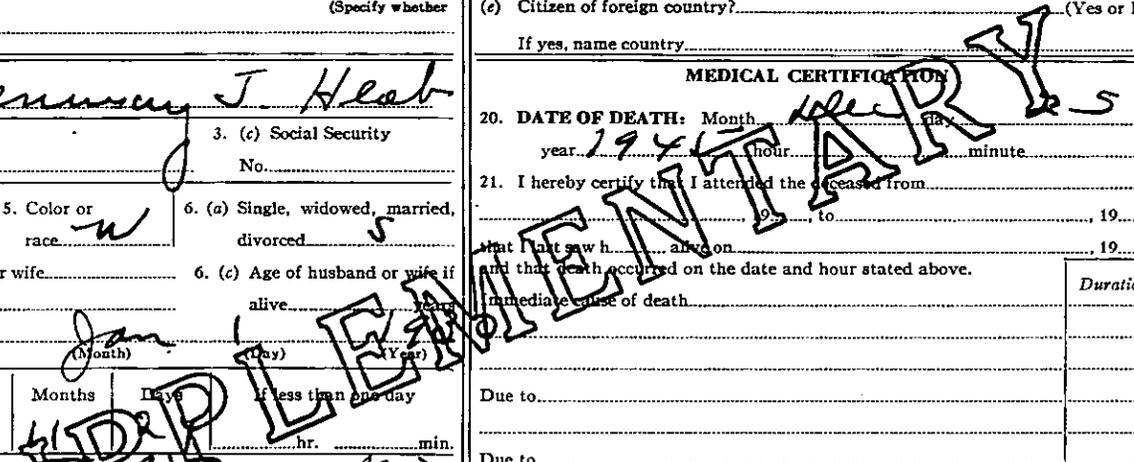
(a) Accident, suicide, or homicide (specify).....
(b) Date of occurrence.....
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?.....

While at work?..... (Specify type of place) (e) Means of injury.....

23. Signature..... (M. D. or other)

Address..... Date signed.....

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



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