

5-17-39  
I X36671

Registration District No. **FE 818** 1946

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:  
**CITY ISOLATION HOSPITAL.**  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution **12/24/45 to 1/30/46**  
 (Specify whether years, months or days)

3. (a) PRINT FULL NAME **EDWIN CHARLES HEUERMAN**

3. (b) If veteran, name war. No. 3. (c) Social Security No.

4. Sex **MALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married divorced **WIDOWER**  
 6. (b) Name of husband or wife. 6. (c) Age of husband or wife if alive. years  
 7. Birth date of deceased **MAR. 17, 1883**  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**62 10 14** hr. min.

9. Birthplace **St Louis MO**  
 (City, town, or county) (State or foreign country)

10. Usual occupation **odd JOBS**

11. Industry or business.

12. Name **HENRY HEUERMAN**  
 13. Birthplace **ST. LOUIS MO.**  
 (City, town, or county) (State or foreign country)  
 14. Maiden name **MINNIE WIGANDMANN**  
 15. Birthplace **ST. LOUIS MO.**  
 (City, town, or county) (State or foreign country)

16. (a) Informant **CITY INFIRMARY RECORDS,**  
 (b) Address **5800 ARSENAL ST.**

17. (a) **Burial** (b) Date thereof **2-1-1946**  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Sunset Burial Park**

18. (a) Signature of funeral director **Gregg Huber Bros.**  
 (b) Address **6409 Gravois Ave.**

19. (a) **FEB 1 1946** (b) **J. F. Bredeh**  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **000**  
 (c) City or town **ST. LOUIS MO.**  
 (If outside city or town limits, write "RURAL") **2317**  
 (d) Street No. **2715a S. BROADWAY**  
 (If rural, give location) **9**  
 (e) Citizen of foreign country? **0** (Yes or No)  
 If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **JAN**, day **30**, year **1946** hour **7** minute **40** P.M.  
 21. I hereby certify that I attended the deceased from **11/8** **1945**, 19 **1/30** **1946**; that I last saw him alive on **1/30** **1946**; and that death occurred on the date and hour stated above.

Immediate cause of death **Myocardial failure**  
 Due to **Coronary artery disease**  
 Due to **arteriosclerosis**  
 Other conditions **heinz plogia**  
 (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)  
 (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 **John E. Allen** (M.D. or other) **MD**  
 Address **5600 Arsenal** Date signed **1/31/46**

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

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**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 Horner H. Dritz  
Licensed Embalmer No. 3882

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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Feb  
Registrar's No. 1082

Registration District No. 318

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town St. Louis  
(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 \_\_\_\_\_ years, months or days)

3. (a) PRINT FULL NAME Edwin C. Hevermann

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 wid

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

7. Birth date of deceased Mar 17 1917  
(Month) (Day) (Year)

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

9. Birthplace St. Louis, Mo  
(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 \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) J. F. Bredeck  
(Date received local registrar) (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 CERTIFICATE

20. DATE OF DEATH: Month \_\_\_\_\_ Day \_\_\_\_\_  
year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I autopsied \_\_\_\_\_ 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) (c) Means of injury \_\_\_\_\_

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

Date signed \_\_\_\_\_

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

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