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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **2126**
Registrar's No. **104**

FILED FEB 11 1946
Registration District No. **42**

Primary Registration District No. **1000**

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

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1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Joseph's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 days
In this community 30 years
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Ora Heil
3. (b) If veteran, name war None
3. (c) Social Security No. None

4. Sex Female 5. Color of race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Edward
6. (c) Age of husband or wife if alive 58 years
7. Birth date of deceased April 8, 1888
(Month) (Day) (Year)

8. AGE: Years 57 Months 9 Days 17
If less than one day hr. min.

9. Birthplace Troy Kansas
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business Home

MOTHER FATHER
12. Name Emil Duback
13. Birthplace Unknown
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Edward Heil (Husband)
(b) Address 2333 So. 6th St., City

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/28/46
(Month) (Day) (Year)
(c) Place: burial or cremation Memorial Park Cemetery

18. (a) Signature of funeral director John E. Lipp
(b) Address 6054 Pryor Ave., City

19. (a) Jan. 29, 1946 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Buchanan
(c) City or town St. Joseph
(If outside city or town limits, write "RURAL")
(d) Street No. 2333 So. 6th St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month January day 25,
year 1946 hour 2 minute 30 P. M.
21. I hereby certify that I attended the deceased from Jan. 20, 1946 to Jan. 25, 1946,
that I last saw her alive on Jan. 25, 1946,
and that death occurred on the date and hour stated above.

Immediate cause of death Apoplexy, cerebral
Duration 5 da.

Due to Arteriosclerosis, general

Due to _____
Other conditions Diabetes Mellitus
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy W
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 [Signature] (M. D. or other)
Address St. Joseph 8, Mo. Date signed Jan 26 1946

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, ~~only~~.....

..... Registered Apprentice No.

working under my personal supervision.

Signed.....

Licensed Embalmer No. *3986*

P. O. Address *St Joseph, 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.