No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 5424

FILED FEB 19 1946

Registration District No. 1

Primary Registration District No. 3025

Registrar's No. 2

6
1
1

100997

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

1. PLACE OF DEATH:

(a) County HOWELL

(b) City or town WEST PLAINS
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
WEST PLAINS HOSPITAL 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 hours (Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County HOWELL 46 0

(c) City or town "RURAL" HOWELL TWP. 0
(If outside city or town limits, write "RURAL")

(d) Street No. WEST PLAINS, MO., RT. 1
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME LINDA SUE HECKART

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex female 1

5. Color or race white

6. (a) Single, widowed, married, divorced infant 0

6. (b) Name of husband or wife

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

7. Birth date of deceased Nov. (Month) 20 (Day) 1945 (Year)

8. AGE: Years — Months — Days — If less than one day 5 hr. min.

9. Birthplace WEST PLAINS, (City, town, or county) Mo 0 (State or foreign country)

10. Usual occupation —

11. Industry or business —

FATHER
12. Name James Heckart
13. Birthplace West Plains, (City, town, or county) Mo. 0 (State or foreign country)

MOTHER
14. Maiden name Ell Nora Rose Young
15. Birthplace Peoria, (City, town, or county) Ill. 1 (State or foreign country)

16. (a) Informant James Heckart
(b) Address West Plains, Mo., Rt I.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. (Month) 21 (Day) 1945 (Year)
(c) Place: burial or cremation Howell Valley Cem Howell Twp. Howell Co.

18. (a) Signature of funeral director Hal Thornburgh
(b) Address West Plains, Mo.

19. (a) Jan. 21, 1946 (Date received local registrar) (b) Gladys Harrison (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 20, year 1945 hour 6: minute 30 P. M.

21. I hereby certify that I attended the deceased from 11/20 1946 to 11/20 1945 that I last saw her alive on 11/20 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Respiratory failure	
Due to	
Due to Premature 8 mo	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations 159	
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? (Specify type of place)

While at work? — (e) Means of injury — 0

23. Signature Maurice Thompson (M. D. or other) MD
Address West Plains Mo Date signed 11/20/46

125 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 5,
District File Number 246255
Date Filed 2.15.46

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.

Not Embalmed

Signed .....

Licensed Embalmer No. .....

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.