

No. 2
M-5-43
5-17-39
X3667

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 16681
Registrar's No. 2357

FILED JUN 10 1946

Registration District No. 11 Primary Registration District No. 1002

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

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution: Research Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 12 days
In this community Non-Resident (Specify whether years, months or days)

3. (a) PRINT FULL NAME LOUIS T. HEISTERBERG

3. (b) If veteran, name war no

3. (c) Social Security No. None

4. Sex Ma 5. Color or race Wh

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Maggie Heisterberg

6. (c) Age of husband or wife if alive 62 years

7. Birth date of deceased April 3, 1883
(Month) (Day) (Year)

8. AGE: Years 63 Months 1 Days 23 If less than one day hr. min.

9. Birthplace Benton Co., Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

MOTHER FATHER

12. Name John Heisterberg

13. Birthplace Benton Co., Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Anna Grannamann

15. Birthplace Benton Co., Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Maggie Heisterberg

(b) Address Cole Camp, Mo.

17. (a) Removal (b) Date thereof 5-27-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cole Camp, Mo.

18. (a) Signature of funeral director J. W. Wagner

(b) Address Kansas City, Mo.

19. (a) 5-27-46 (b) E. Geraldine Holmes
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 8

(c) City or town Cole Camp 0
(If outside city or town limits, write "RURAL")

(d) Street No. 0
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 26 year 46 hour minute M.

21. I hereby certify that I attended the deceased from May 14-46 to 5-26 1946 that I last saw him alive on May 26 and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial infarction (acute Embolus)

Due to Prostatic Hypertrophy Post-operative Incur. Urinary Retention

Other conditions None
(Include pregnancy within 3 months of death)

Major findings: Prostatic Hypertrophy

Of operations Benign

Of autopsy None (System)

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)

(a) Means of injury Chloroform

23. Signature [Signature] (M. D. or MD)

Address 1019 Park Blvd Date 5/27/46

15563

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..... *Cecil R. Matthes*

Licensed Embalmer No. *3807*

P. O. Address..... *Kansas City, 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.