

S. No. 2  
M-5-43  
v. 5-17-39  
I X36671

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

20304

State File No. \_\_\_\_\_  
Registrar's No. 2745

**FILED** JUL 2 1946  
Registration District No. 149

Primary Registration District No. 1682

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:  
628 Brighton /  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community unknown (years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**  
(a) State Missouri (b) County Jackson 48  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL") 3  
(d) Street No. 628 Brighton 8  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No) 0  
If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** Frances Maude Heinzelman  
**3. (b) If veteran,** No **3. (c) Social Security** Unknown  
name war \_\_\_\_\_ No. 500-12-2561  
**4. Sex** F **5. Color or** W **6. (a) Single, widowed, married,** Wid.  
race \_\_\_\_\_ **6. (b) Name of husband or wife** Unknown **6. (c) Age of husband or wife if** 3-26-1888  
alive \_\_\_\_\_ years  
**7. Birth date of deceased** Unknown  
(Month) (Day) (Year)

**MEDICAL CERTIFICATION**  
**20. DATE OF DEATH:** Month June day 19  
year 1946 hour 1 minute \_\_\_\_\_ P. M.  
**21. I hereby certify that I attended the deceased from** Coroner, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw h \_\_\_\_\_ arrive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

**8. AGE:** Years Months Days If less than one day  
58 2 23 hr. \_\_\_\_\_ min. \_\_\_\_\_

Immediate cause of death Coronary sclerosis  
Due to arteriosclerosis  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) 94a

**9. Birthplace** Clinton, Mo.  
(City, town, or county) (State or foreign country)  
order Miller

**Major findings:**  
Of operations \_\_\_\_\_  
Of autopsy no  
Hestry & Guignard

**10. Usual occupation** Keysall Pharmaceutical Co.

**11. Industry or business** Keysall Pharmaceutical Co.

**12. Name** Albert Logan  
**13. Birthplace** unknown  
(City, town, or county) (State or foreign country)  
**14. Maiden name** Rose Lougine  
**15. Birthplace** unknown  
(City, town, or county) (State or foreign country)

**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? \_\_\_\_\_

**16. (a) Informant** Keysall Pharmaceutical Co.  
**(b) Address** 722006 Wyandotte

**17. (a) Burial** Burial **(b) Date thereof** June 21, 1946  
(Burial, cremation, or removal) (Month) (Day) (Year)  
**(c) Place: burial or cremation** Mt. Washington

**23. Signature** Jimmie Walker (M. D. or other) 3  
Address 1424 N. 1st St. Mo. Date signed 6-20-46

**18. (a) Signature of funeral director** C. H. Blackman & Son, Inc.  
**(b) Address** 2825 Independence Blvd.  
**19. (a) 6-20-46** **(b) Geraldine Holmes**  
(Date received local registrar) (Registrar's signature)

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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 W. H. Blackman  
Licensed Embalmer No. 3639  
P. O. Address K.C., 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.**