

FILED JUL 15 1947

Registration District No. **B 60**

Primary Registration District No. **6225**

Registrar's No. **116**

1. PLACE OF DEATH:

(a) County **Benton**
(b) City or town **Washburn**
(c) Name of hospital or institution **State Hospital #32**
(d) Length of stay: In hospital or institution **17 1/2 years 4 months 3 days**
In this community **17 years 4 months 3 days**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Benton**
(c) City or town **Cole Camp**
(d) Street No. **V**
(e) If foreign born, how long in U. S. A? **no** years.

3. (a) PRINT FULL NAME **ALEX HEIMSOOTH**

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

4. Sex **m** Color or race **W** 6. (a) Single, widowed, married, divorced **Single**

6. (b) Name of husband or wife **V** 6. (c) Age of husband or wife if alive **years**

7. Birth date of deceased **Oct 15 1881**
(Month) (Day) (Year)

8. AGE: Years **65** Months **6** Days **8** 17 hr. min.

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

10. Usual occupation **Farming**

11. Industry or business
MOTHER FATHER { 12. Name **Henry Heimsooth**
13. Birthplace **Washburn**
14. Maiden name **Washburn**
15. Birthplace **" "**

16. (a) Informant **Hospital Record**

(b) Address **Wadada, Missouri**

17. (c) **Removal** (b) Date thereof **7-3-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Springfield, Mo**

18. (a) Signature of funeral director **Wadada, Mo**
(b) Address **Wadada, Mo**

19. (a) **7-7-47** (b) **Wadada, Mo**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **2**
year **1947** hour **9** minute **30** p.m.

21. I hereby certify that I attended the deceased from **Oct 1 1943** to **July 2 1947**
that I last saw him alive on **July 2 1947**
and that death occurred on the date and hour stated above.

Immediate cause of death **Pulmonary Tuberculosis**

Due to **V**
Due to **V**

Other conditions **V**
(Include pregnancy within 3 months of death)

Major findings: **V**
Of operations **V**
Of autopsy **V**

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) (Means of injury)

23. Signature **Wadada, Mo** (M. D. or other)
Address **Wadada, Mo** Date signed **7-2-47**

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

RECEIVED
District Health Officer No. 7,
District File Number 6-47-828
Date Filed 7-19-47

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 Mark Eichinger

Licensed Embalmer No. 25656

P. O. Address Newark, 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, above space should be left blank.