

U. S. No. 2
FORM-5-43
Rev. 5-17-39
I X36671

FILED NOV 19 1947

Registration District No. **117**

Primary Registration District No. **5435**

Registrar's No. **3**

1. PLACE OF DEATH:

(a) County Gasconade

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

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

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community Lifetime
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Gasconade **37**

(c) City or town Rural
(If outside city or town limits, write "RURAL")

(d) Street No. 12 Miles South of Hermann, Mo
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME ARNOLD EDWARD HEINLEIN

3. (b) If veteran, name war 1ST World War

3. (c) Social Security No. None

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Ida Heinlein

6. (c) Age of husband or wife if alive 48 years

7. Birth date of deceased Sept. 3rd 1887
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>60</u>		<u>29</u>	hr. _____ min. _____

9. Birthplace Gasconade County, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business Farming

12. Name Edward Heinlein

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

14. Maiden name Marie Gumper

15. Birthplace Unknown, Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Earl Heinlein

(b) Address New Haven, Mo. RFD

17. (a) Burial (b) Date thereof 10/5/1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Stonyhill, Mo.

18. (a) Signature of funeral director James Blumer

(b) Address Berger, Missouri

19. (a) 10/4/47 (b) W. M. Maxwell
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 2nd
year 1947 hour 10 minute 45 A.M.

21. I hereby certify that I attended the deceased from August 4
1947 to October 2, 1947,
that I last saw him alive on September 30, 1947,
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebro-vascular accident - left hemiplegia

Duration
<u>2 mo.</u>
<u>3 years</u>

Due to Arterial hypertension

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings:
Of operations None
Of autopsy None

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)
(e) Means of injury 0

23. Signature Cavel T. Shaw, MO (M. D. or other)

Address Hermann, Mo. Date signed 10-3

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

MOTHER, FATHER

RECEIVED
District Health Officer No. 9,
District File Number
NOV 18 1947
Date Filled

NOV 19 1947

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 *Herman Blauer*.....

Licensed Embalmer No. *528*.....

P. O. Address *Bergen Mc*.....

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.