

FILED FEB 8 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 10

BIRTH NO. _____		REG. DIST. NO. <u>1</u>		PRIMARY REG. DIST. NO. <u>3000</u>		Registrar's No. <u>41</u>	
1. PLACE OF DEATH a. COUNTY <u>Adair</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Adair</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kirksville</u>		c. LENGTH OF STAY (in this place) <u>4 mo. 13 da.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kirksville</u>			
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Grim-Smith Memorial Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>806 S. Halliburton Street</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Jacob</u>		b. (Middle) <u>W.</u>		c. (Last) <u>Heyd</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 27 1949</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Jan. 8, 1875</u>	
9. AGE (In years last birthday) <u>74</u>		10. MONTHS <u>0</u>		11. DAYS <u>19</u>		IF UNDER 1 YEAR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired College Professor KSTC</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Adair County, Missouri</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13a. FATHER'S NAME <u>Jacob Heyd</u>			13b. MOTHER'S MAIDEN NAME <u>Elizabeth Scheer</u>			14. NAME OF HUSBAND OR WIFE <u>Flora Schlierhartz Heyd</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Flora Heyd</u> ADDRESS <u>806 S. Halliburton, Kirksville, Mo.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>arteriosclerosis, diffuse</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>MI</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>No</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9-14, 1948</u> , to <u>1-27, 1949</u> , that I last saw the deceased alive on <u>1-27, 1949</u> , and that death occurred at <u>5:55 P.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>George E. Grim MD</u>				23b. ADDRESS <u>Kirksville, Mo.</u>		23c. DATE SIGNED <u>1-28-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>1-31-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Maple Hills Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Kirksville, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>2-1-49</u>		REGISTRAR'S SIGNATURE <u>Kate Lambert</u>		FUNERAL DIRECTOR'S SIGNATURE <u>Davis Funeral Home</u>		ADDRESS <u>Kirksville, Mo.</u>	

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

RECEIVED

District Health Officer No. 10

District File Number 2-49-240

Date Filed FEB 7 - 1949

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~~

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed Clarence M. Bills

Licensed Embalmer No. 4375

P. O. Address Kirkville, 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.