

FILED APR 14 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **11198**

BIRTH NO.		REG. DIST. NO. <b>230</b>		PRIMARY REG. DIST. NO. <b>61124</b>		Registrar's No. <b>6</b>									
1. PLACE OF DEATH a. COUNTY <b>SCOTT</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE <b>Mo</b> b. COUNTY <b>SCOTT</b>											
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>KELSO</b>		c. LENGTH OF STAY (in this place) <b>38 yrs</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>KELSO, Mo</b>											
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>L I</b>				d. STREET ADDRESS (If rural, give location) <b>L</b>											
3. NAME OF DECEASED (Type or Print)			a. (First) <b>GOLUTTA</b>			b. (Middle) <b>J. HEISERER</b>			c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) <b>4-1-1949</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED, NEVER MARRIED; WIDOWED, DIVORCED (Specify) <b>MARRIED</b>		8. DATE OF BIRTH <b>DEC. 5-1910</b>		9. AGE (In years last birthday) <b>38</b>		IF UNDER 1 YEAR Months <b>3</b>		IF UNDER 24 HRS. Days <b>27</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>				11. BIRTHPLACE (State or foreign country) <b>KELSO, Mo.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13a. FATHER'S NAME <b>LEO BUCKER</b>				13b. MOTHER'S MAIDEN NAME <b>TERESA HEURING</b>				14. NAME OF HUSBAND OR WIFE <b>RAYMOND HEISERER</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO.				17. INFORMANT'S SIGNATURE OR NAME <b>RAYMOND HEISERER, KELSO, Mo</b>				ADDRESS			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Chest Injury, Hemorrhage</b> <b>Car accident</b> 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.								INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION <b>68124/1</b> <b>25</b>								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>accident</b>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>Highway 61, Kelso Scott Mo.</b>									
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>4 1 49 m.</b>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>Hit by carle crossing highway</b>											
22. I hereby certify that I attended the deceased from <b>First call</b> after death, 19___, to ___ after death, 19___, that I last saw the deceased alive on ___, 19___, and that death occurred at ___ m., from the causes and on the date stated above.															
23a. SIGNATURE <b>Clayton P. Coroner</b>						23b. ADDRESS <b>Sikeston Mo</b>				23c. DATE SIGNED <b>4/2/49</b>					
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24b. DATE <b>APR. 5-1949</b>		24c. NAME OF CEMETERY OR CREMATORY <b>ST. AUGUSTINE</b>				24d. LOCATION (City, town, or county) (State) <b>KELSO, Mo.</b>							
DATE REC'D BY LOCAL REG. <b>4-5-49</b>		REGISTRAR'S SIGNATURE <b>3. 2. 2</b>				5. FUNERAL DIRECTOR'S SIGNATURE <b>Walther Funeral Home</b>				ADDRESS <b>Loafe. Gir. Mo.</b>					

(Licensed Embalmer's Statement on Reverse Side)

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

JUN 9 1949  
DEC 13 1949

RECEIVED

District Health Office No. 2

District File Number 49-470

Date Filed 4-12-49

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 Virgil H. Kelch

Licensed Embalmer No. 4102

P. O. Address Cape Girardeau

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.