

FILED MAY 3 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

12451
State File No. 1697

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

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>57</u>	
b. CITY OR TOWN <u>KANSAS CITY</u>		c. CITY OR TOWN <u>CHILlicoTHE</u>	
c. LENGTH OF STAY (in this place) <u>4 DAYS</u>		d. STREET ADDRESS (If rural, give location) <u>823 BROADWAY</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>TRINITY LUTHERAN HOSP.</u>			
3. NAME OF DECEASED (Type or Print) <u>MRS. EDNA LOUISE HECKER</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>APRIL-17-1949</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>AUG. 19, 1923</u>
9. AGE (In years last birthday) <u>25</u>		10. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>Unionville, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13a. FATHER'S NAME <u>unknown</u>		13b. MOTHER'S MAIDEN NAME <u>unknown</u>	
14. NAME OF HUSBAND OR WIFE <u>ROBERT B. HECKER</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>No.</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>ROBERT B. HECKER</u>		ADDRESS <u>CHILlicoTHE, MO.</u>	
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH: <u>stroke following operation 4-16-49 for a toxic thyroid -</u> ANTECEDENT CAUSES <u>thyroidosis</u> DUE TO (a) <u>thyroidosis</u> DUE TO (b) <u>thyroidosis</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>25</u>	
19a. DATE OF OPERATION <u>4-16-49</u>		19b. MAJOR FINDINGS OF OPERATION <u>Large thyroid gland</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		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>4-13</u> , 1949, to <u>4-17</u> , 1949, that I last saw the deceased alive on <u>4-17</u> , 1949, and that death occurred at <u>12:40 P.M.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>Geo. B. Norberg</u> (Degree or title)		23b. ADDRESS <u>Trinity Lutheran Hospital</u>	
23c. DATE SIGNED <u>4-17-49</u>			
24a. BURIAL OR CREMATION REMOVAL (Specify) <u>REMOVAL</u>		24b. DATE <u>April 17, 1949</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>Unionville, Mo.</u>		24d. LOCATION (City, town, or county) (State) <u>Unionville, Missouri</u>	
DATE REC'D BY LOCAL REG. <u>4-17-49</u>		REGISTRAR'S SIGNATURE <u>Sheraldine Holmes</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>D. H. Newcomer</u>		ADDRESS <u>San. K. C. Mo.</u>	

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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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

John T. Deuss

Licensed Embalmer No. 445-3

P. O. Address Kansas City

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.