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

FILED JUL 15 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 21137

BIRTH NO. _____ REG. DIST. NO. 318 1003 ~~HOMER G. PHELPS HOSPITAL~~ Registrar's No. 5282

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ST. LOUIS
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1401 A SALISBURY

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo
b. COUNTY: 000
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ST. LOUIS 17
d. STREET ADDRESS (If rural, give location): 1401 A SALISBURY

3. NAME OF DECEASED (Type or Print)
a. (First): MARY
b. (Middle): SLICK
c. (Last): HEIDEMANN

4. DATE OF DEATH (Month) JULY (Day) 4 (Year) 1949

5. SEX: FEMALE
6. COLOR OR RACE: W.
7. MARRIED, ~~NEVER MARRIED, WIDOWED, DIVORCED~~ (Specify): M.
8. DATE OF BIRTH: MAY 23-1882
9. AGE (In years last birthday): 67 YRS
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEKEEPER
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): ST. LOUIS MO.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME: THOMAS NORRIS
13b. MOTHER'S MAIDEN NAME: MARY JANE DILLON
14. NAME OF HUSBAND OR WIFE: Wm Heidemann
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S SIGNATURE OR NAME: Wm Heidemann
ADDRESS: 1401 A Salisbury

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Oedema — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Aortic Stenosis
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:
20. AUTOPSY? YES ☐ NO ☐
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): 92
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? 4211

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at* 753 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Alfred J. Perry Dep Cor B
23b. ADDRESS: 1300 Clark
23c. DATE SIGNED: 7-5-49
24a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24b. DATE: JULY 7-49
24c. NAME OF CEMETERY OR CREMATORY: CALVARY Cem.
24d. LOCATION (City, town, or county) (State): St Louis Mo.
DATE REC'D BY LOCAL REG.: JUL 8 1949
REGISTRAR'S SIGNATURE: J B Lashley
25. FUNERAL DIRECTOR'S SIGNATURE: E. J. Schnur
ADDRESS: 3125 Lafayette Av

(Licensed Embalmer's Statement on Reverse Side)

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.

Signed.....

Signed.....
Student Embalmer

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.