

FILED OCT 28 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **34403**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **209** PRIMARY REG. DIST. NO. **3043** Registrar's No. **354**

1. PLACE OF DEATH a. COUNTY <b>Marion</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Marion</b>	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN) <b>Hannibal</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Rural</b>	
c. LENGTH OF STAY (in this place) <b>2 days</b>		d. STREET ADDRESS (If rural, give location) <b>/</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Elizabeth Hospital</b>			

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) <b>John</b>	b. (Middle) <b>Herman</b>	c. (Last) <b>Heitholt</b>	<b>Sept. 21st 1949</b>		

5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>July 18th 1883</b>	9. AGE (In years last birthday) <b>66</b>	IF UNDER 1 YEAR Months <b>2</b>	IF UNDER 1 YEAR Days <b>3</b>	IF UNDER 24 HRS. Hours <b></b>	IF UNDER 24 HRS. Min. <b></b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Quincy Ill.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Peter Heitholt</b>	13b. MOTHER'S MAIDEN NAME <b>Minnie Bresser</b>	14. NAME OF HUSBAND OR WIFE <b>*****</b>
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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. <b>*****</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Henry Heitholt</b>	ADDRESS <b>Woodland MO.</b>
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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		INTERVAL BETWEEN ONSET AND DEATH  <b>332X</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral Thrombosis</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. <b>Bronchial Pneumonia (Pneumol)</b>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **Sept. 19, 1949**, to **Sept. 21, 1949**, that I last saw the deceased alive on **Sept. 20, 1949** and that death occurred at **6 1/2** m., from the causes and on the date stated above.

23a. SIGNATURE <b>E. M. Lucke M.D., U</b>	(Degree or title)	23b. ADDRESS <b>Hannibal Mo</b>	23c. DATE SIGNED <b>10-31-49</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>Sept 23 1949</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Greenwood</b>	24d. LOCATION (City, town, or county) (State) <b>Palmyra Mo.</b>
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DATE REC'D BY LOCAL REG. <b>10-20-49</b>	REGISTRAR'S SIGNATURE <b>Dr. E. M. Lucke Deputy</b>	FUNERAL DIRECTOR'S SIGNATURE <b>E. J. Sprague</b>	ADDRESS <b>Palmyra Mo.</b>
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(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED OCT 27 1949  
MARION CO. HEALTH DEPT.  
DATE FILED OCT 27 1949

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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.

Signed E. J. Sprague

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. 3245

P. O. Address Palmyra 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.