

FILED NOV 21 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39510

State File No. 3063

Registrar's No. 4328

No. 300
10.48

46

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

BIRTH NO. _____		REG. DIST. NO. 317		PRIMARY REG. DIST. NO. 6076		State File No. 3063		Registrar's No. 4328	
1. PLACE OF DEATH a. COUNTY ST. LOUIS				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO. b. COUNTY ST. LOUIS					
b. CITY (If outside corporate limits, write RURAL and give township) CLAYTON		c. LENGTH OF STAY (in this place) 1 WK.		c. CITY (If outside corporate limits, write RURAL and give township) LEMAY		9-2			
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. LOUIS COUNTY HOSP.				d. STREET ADDRESS 206 E. ETTA					
3. NAME OF DECEASED (Type or Print) a. (First) EDWARD		b. (Middle) H		c. (Last) HEITZ		4. DATE OF DEATH (Month) (Day) (Year) NOV 4 1949			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED		8. DATE OF BIRTH 2-15-1894		9. AGE (In years last birthday) 55	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY LUMBER		11. BIRTHPLACE (State or foreign country) ST. LOUIS MO.			12. CITIZEN OF WHAT COUNTRY? US		
13a. FATHER'S NAME LEO H HEITZ			13b. MOTHER'S MAIDEN NAME MATHILDA			14. NAME OF HUSBAND OR WIFE JULIUS MARI			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) UNK.		16. SOCIAL SECURITY NO. UNK.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Edw. M. Heitz, 9975 Clyde					
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.		1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Respiratory obstruction & failure ANTECEDENT CAUSES DUE TO (b) Carcinoma of larynx DUE TO (c) Cirrhosis of liver Pulmonary tuberculosis						19. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH 8 mos 16X 16X	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? YES <input checked="" 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)		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 10-27-1949, to 11-4-1949, that I last saw the deceased alive on 11-4-1949, and that death occurred at 4:30 a.m., from the causes and on the date stated above.									
23a. SIGNATURE John F. Gaines, M.D.				23b. ADDRESS 601 BRENTWOOD, CLAYTON		23c. DATE SIGNED 11-5-49			
24a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		24b. DATE 11-8-49		24c. NAME OF CEMETERY OR CREMATORY St. Peter's Paul		24d. LOCATION (City, town, or county) St. Louis		(State) MO	
DATE REC'D BY LOCAL REG. 11-5-49		REGISTRAR'S SIGNATURE Herbert G. Womble, M.D.		FUNERAL DIRECTOR'S SIGNATURE J. J. Javelle, Jr.		ADDRESS 7178 Michigan			

(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.

Student

Student Embalmer

Signed _____

Clarence Rochow

Licensed Embalmer No. 3093

P. O. Address 7128 Michigan

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.