

FILED SEP 6 1950

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State File No. 7369

7369

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (in this place) <u>50-yrs.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Bel-Nor</u>		4180	
d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>Christian Hospital</u>				8. STREET ADDRESS (If rural, give location) <u>3071 Andover Drive</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Vernie</u> b. (Middle) <u>J.</u> c. (Last) <u>Heitmeier</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 27, 1950</u>				
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED. (Specify) <u>W.</u>	8. DATE OF BIRTH <u>Jan. 8, 1868</u>	9. AGE (In years last birthday) <u>82</u>	IF UNDER 1 YEAR Months <u>6</u> Days <u>19</u>	IF UNDER 4 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired). <u>Retired, Salesman, Simons Hdw. Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Simons Hdw. Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Carlyle, Ill.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13a. FATHER'S NAME <u>Fred Heitmeier</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Kathryn Heitmeier</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>none</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Lillian Heitmeier, 3071 Andover Dr.</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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cardiac Decompensation</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>uremia (Nephritis etc)</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>---</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) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>592X</u>			
22. I hereby certify that I attended the deceased from <u>1-10-1949</u> to <u>8-27-1950</u> , that I last saw the deceased alive on _____, 19____, and that death occurred at <u>1:50 PM</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>L. J. Knick M.D.</u>		23b. ADDRESS <u>608 Kingsland</u>		23c. DATE SIGNED <u>8-28-50</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Aug. 30, 1950</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>AUG 29 1950</u>		REGISTRAR'S SIGNATURE <u>J. B. Fasano</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur J. Donnelly</u>		ADDRESS <u>Lindell Blvd.</u>	

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

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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 _____

W H Van Matre

Licensed Embalmer No. 2825

P. O. Address 4340 Lafayette

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.