

FILED DEC 1 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 38599

#115638

REG. DIST. NO. 318

PRIMARY REG. DIST. NO. 1003

Registrar's No. 3872

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo		b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Missouri		c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS 2039	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1.		STREET ADDRESS (If rural, give location) 3405 MANHATTAN AV			

3. NAME OF DECEASED (Type or Print)		a. (First) ALICE	b. (Middle)	c. (Last) HEISEL	4. DATE OF DEATH (Month) (Day) (Year) Nov. 20th, 1950	
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5. SEX FE	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) W	8. DATE OF BIRTH APRIL-6-1869	9. AGE (In years last birthday) 81 YRS	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NIL	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) AUBURN ILLINOIS	12. CITIZEN OF WHAT COUNTRY U. S. A.
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13a. FATHER'S NAME CHRISTOPHER C. HATCHER	13b. MOTHER'S MAIDEN NAME AMANDA BROOKS	14. NAME OF HUSBAND OR WIFE JOHN W. HEISEL
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Beatrice Harrison 3405 Manhattan
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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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral malaria</u>		INTERVAL BETWEEN ONSET AND DEATH  6 wks.
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cerebral thrombosis</u>		
	DUE TO (c) <u>Cerebral arteriosclerosis</u>		
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 <input type="checkbox"/> NO <input checked="" 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 332X
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22. I hereby certify that I attended the deceased from 10/8/50, 19\_\_\_, to 11/20/50, 19\_\_\_, that I last saw the deceased alive on 11/20/50, 19\_\_\_, and that death occurred at 8:20pm m., from the causes and on the date stated above.

23a. SIGNATURE John T. Lawton, M.D.	23b. ADDRESS 1515 Lafayette Ave.,	23c. DATE SIGNED 11/21/50
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24a. BURIAL, CREMATION, OR REMOVAL (Specify) BURIAL	24b. DATE Nov. 22-50	24c. NAME OF CEMETERY OR CREMATORY AUBURN	24d. LOCATION (City, town, or county) (State) AUBURN ILLINOIS
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DATE REC'D BY LOCAL REG. NOV 21 1950	REGISTRAR'S SIGNATURE J. B. Foster	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS E. J. Schmur 3125 Lafayette Ave.
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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 \_\_\_\_\_

working under my personal supervision.

Student Embalmer No. ....

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 with the above constitutes grounds for revocation of license.)

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