

FILED JAN 10 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **43007**

318

1003

Registrar's No. **11039**

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|--|--|--|--|--|--|--|--|----------------------------------|--|
| BIRTH NO. _____ | | REG. DIST. NO. _____ | | PRIMARY REG. DIST. NO. _____ | | Registrar's No. 11039 | | | |
| 1. PLACE OF DEATH a. COUNTY _____ | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY 2249 | | | | | |
| b. CITY OR TOWN St. Louis | | c. LENGTH OF STAY (In this place) _____ | | c. CITY OR TOWN St. Louis | | d. STREET ADDRESS (If rural, give location) 3157 Iowa Ave. (rear) | | | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hospital | | | | | | | | | |
| 3. NAME OF DECEASED (Type or Print) Barbara Heilich | | | a. (First) _____ b. (Middle) _____ c. (Last) _____ | | | 4. DATE OF DEATH (Month) (Day) (Year) 12/12/51 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married | | 8. DATE OF BIRTH Nov. 20, 1869 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home | | 10b. KIND OF BUSINESS OR INDUSTRY _____ | | 9. AGE (In years last birthday) 82 | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. BIRTHPLACE (State or foreign country) Hungary | | | | | | | | | |
| 13a. FATHER'S NAME John Backes | | 13b. MOTHER'S MAIDEN NAME Barbara Schaefer | | 14. NAME OF HUSBAND OR WIFE Michael | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. _____ | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Michael Heilich-3157 Iowa (rear) | | | | | |
| 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, athenia, etc. It means the disease, injury, or complication which caused death. | | | | MEDICAL CERTIFICATION | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) EMBOLISM LEFT FEMORAL ARTERY | | | | DUE TO (b) AURICULAR FIBRILLATION | | | | 10 DAYS | |
| ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) ARTERIOSCLEROTIC HEART DISEASE | | | | | | | | 6 MONTHS | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | | | | | | 6 MONTHS | |
| 19a. DATE OF OPERATION _____ | | 19b. MAJOR FINDINGS OF OPERATION _____ | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) (m.) _____ | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? H200 | | | | | |
| 22. I hereby certify that I attended the deceased from MAY , 19 51 , to DEC 12 , 19 51 , that I last saw the deceased alive on DEC 12 , 19 51 , and that death occurred at 1:55a m. , from the causes and on the date stated above. | | | | | | | | | |
| 23a. SIGNATURE (Degree or title) Gray A. Hammond MD | | | | 23b. ADDRESS 5203 Chippewa | | 23c. DATE SIGNED 12/13/51 | | | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24b. DATE 12/15/51 | | 24c. NAME OF CEMETERY OR CREMATORY Resurrection Cem. | | 24d. LOCATION (City, town, or county) (State) St. Louis Co., Missouri | | | |
| DATE REC'D BY LOCAL REG. DEC 19 1951 | | REGISTRAR'S SIGNATURE Barb Smith MD | | 25. FUNERAL DIRECTOR'S SIGNATURE Wacker-Heldule | | ADDRESS 3634 Gravois | | | |

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

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 Robert C. Wheeler

Licensed Embalmer No. 3128

P. O. Address Stamms

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.