S. No. 300
V. 10.48

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

FILED SEP 9 - 1952

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 27056

BIRTH NO. _____ REG. DIST. NO. 10 PRIMARY REG. DIST. NO. 3002 Registrar's No. 136

1. PLACE OF DEATH
a. COUNTY AUDRAIN 0043 0
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) MEXICO
c. LENGTH OF STAY (in this place) _____
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) AUDRAIN County Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE MO
b. COUNTY AUDRAIN
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) VANDALIA MO 0041 1
d. STREET ADDRESS (If rural, give location) _____

3. NAME OF DECEASED (Type or Print)
a. (First) BOBBIE
b. (Middle) GENE
c. (Last) HEASTON

4. DATE OF DEATH (Month) (Day) (Year) AUG 24 1952

5. SEX M
6. COLOR OR RACE W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER MARRIED
8. DATE OF BIRTH APRIL 7 1952
9. AGE (In years last birthday) IF UNDER 1 YEAR Months 4 Days 21 IF UNDER 24 HRS. Hours _____ Min. _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____
10b. KIND OF BUSINESS OR INDUSTRY _____
11. BIRTHPLACE (State or foreign country) TOKYO JAPAN
12. CITIZEN OF WHAT COUNTRY? JAPAN

13a. FATHER'S NAME DONALD HEASTON
13b. MOTHER'S MAIDEN NAME TOSHITO YOSHIDA
14. NAME OF HUSBAND OR WIFE _____

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____ (If yes, give war or dates of service) _____
16. SOCIAL SECURITY NO. _____
17. INFORMANT'S SIGNATURE OR NAME DONALD HEASTON ADDRESS VANDALIA MO

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____ INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Gastro-enteritis — 3 days
DUE TO (c) _____

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 5710
20. AUTOPSY? YES ☐ NO ☑

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 ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 24, 1952, *to* Aug 28, 1952, *that I last saw the deceased alive on* Aug 28, 1952, *and that death occurred at* 1:30 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE L. Lachance, M.D. (Degree or title)
23b. ADDRESS Centralia, Mo.
23c. DATE SIGNED 9-2-52

24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
24b. DATE 9-28-52
24c. NAME OF CEMETERY OR CREMATORY FARBER CEMETERY
24d. LOCATION (City, town, or county) (State) FARBER MO

DATE REC'D BY LOCAL REG. Sept 2-1952
REGISTRAR'S SIGNATURE Blanche Neely
25. FUNERAL DIRECTOR'S SIGNATURE Glen E. Smith ADDRESS Vandalia Mo

(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 Charles V. Fleming

Licensed Embalmer No. 4625

P. O. Address Mexico 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.