

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **36459**  
Registrar's No. **9141**

FILED OCT 21 1952

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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 _____				
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>Life</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		<u>2059</u>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>5855 Waterman Ave.</u>				d. STREET ADDRESS (If rural, give location) <u>5855 Waterman Ave.</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>Catherine</u>		b. (Middle) _____		c. (Last) <u>Heckman</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 1, 1952</u>		
5. SEX <u>F.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>W.</u>		8. DATE OF BIRTH <u>Oct. 23, 1870</u>		
9. AGE (In years - last birthday) <u>81</u>		IF UNDER 1 YEAR Months <u>11</u> Days <u>8</u>		IF UNDER 12 HRS. Hours _____ Min. _____				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <u>St. Louis, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13a. FATHER'S NAME <u>Thomas Holden</u>			13b. MOTHER'S MAIDEN NAME <u>Catherine Meehan</u>			14. NAME OF HUSBAND OR WIFE <u>Peter Heckman</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. Walter F. Archibald, 5855 Waterman Ave.</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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Arteriosclerosis H.D.</u>  ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis</u>  DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Cerebral Arteriosclerosis</u>					INTERVAL BETWEEN ONSET AND DEATH	
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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR <u>4200</u>				
22. I hereby certify that I attended the deceased from <u>9/29</u> , 19 <u>52</u> , to <u>10-1</u> , 19 <u>52</u> , that I last saw the deceased alive on <u>10/1/52</u> , and that death occurred at <u>8:10 pm.</u> , from the causes and on the date stated above.								
23a. SIGNATURE <u>W. Hayden MD</u>				23b. ADDRESS <u>730 Hodesway</u>		23c. DATE SIGNED <u>10-2-52</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Oct. 4, 1952</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>		
DATE RECD BY LOCAL OFFICE <u>OCT 2 1952</u>		REGISTRAR'S SIGNATURE <u>Charles Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Walter J. Donnelly</u>		ADDRESS <u>3840 Lindell Blvd.</u>		

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

(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 \_\_\_\_\_

*William Matre*

Licensed Embalmer No. 2825

P. O. Address 3840 Lindell

**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.