

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **40945**

FILED DEC 6 1952

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 541 Registrar's No. 3090

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

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Clayton		c. LENGTH OF STAY (In this place) 4 Wks.	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis County Hospital		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Robertson	
		d. STREET ADDRESS (If rural, give location) 627 Hall Ave.	

3. NAME OF DECEASED (Type or Print) a. (First) Hilda b. (Middle) M. c. (Last) Heihn			4. DATE OF DEATH (Month) (Day) (Year) 12 / 1 / 52		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH 12/1/52		9. AGE (In years last birthday) 46		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home	
11. BIRTHPLACE (City and State or Foreign Country) Blair Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.A.		10b. KIND OF BUSINESS OR INDUSTRY Housewife	

13a. FATHER'S NAME Fred Kruse		13b. MOTHER'S MAIDEN NAME Louise Dannenberg		14. NAME OF HUSBAND OR WIFE George Heihn Sr.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS George Heihn Sr. 627 Hall Ave.	

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, assthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Carcinomatous				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) Carcinoma of sigmoid colon				
		DUE TO (c) _____				
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 153X				

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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 11-5, 1952 to 12-1, 1952, that I last saw the deceased alive on 12-1, 1952, and that death occurred at 11:20 Pm., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Dr. Herbert C. Hester, M.D.		23b. ADDRESS 601 S. Brentwood Clayton		23c. DATE SIGNED 12-2-52	
24a. BURIAL, CREMATION, OR OTHER DISPOSITION Burial		24b. DATE 12/5/52		24c. NAME OF CEMETERY OR CREMATORY St. Johns Lutheran Cem. Chester Illinois	
24d. LOCATION (City, town, or county) (State)					

DATE REC'D BY LOCAL REG. 12-2-52		REGISTRAR'S SIGNATURE Herbert R. Dando, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 10123 St. Charles Ave. St. Charles, Mo.	
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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

Sheldon Collier

Licensed Embalmer No. *3382*

P. O. Address *10123 St. Charles*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

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