

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **10452**

BIRTH NO. _____ REG. DIST. NO. **175** PRIMARY REG. DIST. NO. **3036** Registrar's No. **31**

551

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

1. PLACE OF DEATH a. COUNTY LAWRENCE			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY LAWRENCE		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN AYVORA, MO		c. LENGTH OF STAY (in this place)	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN AYVORA 0551		d. STREET ADDRESS (If rural, give location) 136 W. Anderson 0
d. FULL NAME OF HOSPITAL OR INSTITUTION 136 W. ANDERSON			d. STREET ADDRESS (If rural, give location) 136 W. Anderson 0		
3. NAME OF DECEASED (Type or Print) a. (First) HEYMANN b. (Middle) VOH3 c. (Last) VOH3			4. DATE OF DEATH (Month) (Day) (Year) March 14 1953		
5. SEX M	6. COLOR OR RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH SEPT 23-1884	9. AGE (in years last birthday) 68	10. IF UNDER 1 YEAR Months 5 Days 21 Hours Mins.
10a. USUAL OCCUPATION (Give kind of work constituting most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARMING	11. BIRTHPLACE (City and State or Foreign Country) Carroll, Ark		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME John Voh3		13b. MOTHER'S MAIDEN NAME Luliana Markman	14. NAME OF HUSBAND OR WIFE Margaret Voh3		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war of date of service) no		16. SOCIAL SECURITY NO. 486-30-6876	17. INFORMANT'S SIGNATURE OR NAME Margaret Voh3 ADDRESS Aurora, 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, asthma, etc. It means the disease, injury, or complication which caused death.			I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis		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) _____ 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 4201				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?			
22. I hereby certify that I attended the deceased from Jan 10 1950 , to Mar 14 1953 , that I last saw the deceased alive on Mar 14 1953 , and that death occurred at 12 P.m. , from the causes and on the date stated above.					
23a. SIGNATURE Milton A. Davis D.O. (Degree or title)		23b. ADDRESS Aurora Mo.		23c. DATE SIGNED 3/10/53	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 3/18/53	24c. NAME OF CEMETERY OR CREMATORY Grace Lawn	24d. LOCATION (City, town, or county) (State) Edmond, Ark.		
DATE REC'D BY LOCAL REG. March 16 1953	REGISTRAR'S SIGNATURE Oran M. Nott	157	25. FUNERAL DIRECTOR'S SIGNATURE Richard L. Marshall ADDRESS Aurora, Mo.		

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 _____

[Handwritten signature]

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed *[Handwritten signature]*

Licensed Embalmer No. *3812*

P. O. Address *[Handwritten 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.