

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

44253

State File No. ....

FILED DEC 16 1953

Registrar's No. 10916

|   |  |  |                                       |   |  |   |   |  |  |
|---|--|--|---------------------------------------|---|--|---|---|--|--|
| BIRTH NO. ....  |  | REG. DIST. NO. 318   |                                       | PRIMARY REG. DIST. NO. 1003 <sup>N</sup>  |  | Registrar's No. 10916   |   |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY  |  |  |                                       | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE Missouri |  |   |   | b. COUNTY  |  |
| b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN St. Louis  |  | c. LENGTH OF STAY (in this place) 2 Mo. 5 da.  |                                       | c. CITY OR TOWN Lemay   |  | d. Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> |   |  |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION St. Anthonys Hospital   |  |  |                                       | e. STREET ADDRESS (If rural, give location) R. R #8, Box 1685   |  |   |   | 4000 / 1   |  |
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) Frank   |  |  | b. (Middle) J.                        |   | c. (Last) Heimos, Sr.  |   | 4. DATE OF DEATH (Month) (Day) (Year) Nov. 15, 1953 |  |  |
| 5. SEX Male   |  | 6. COLOR OR RACE White   |                                       | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married  |  | 8. DATE OF BIRTH June 20, 1899  |   | 9. AGE (In years last birthday) 64   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer  |  | 10b. KIND OF BUSINESS OR INDUSTRY Own Farm   |                                       | 11. BIRTHPLACE (City and State or Foreign Country) Missouri   |  | 12. CITIZEN OF WHAT COUNTRY? USA  |   |  |  |
| 13a. FATHER'S NAME Frank Heimos   |  |  | 13b. MOTHER'S MAIDEN NAME Anna George |   |  | 14. NAME OF HUSBAND OR WIFE Mildred Heimos  |   |  |  |
| 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 AND ADDRESS Mildred Heimos, RR.#8, Box 1685                               |  |   |   |  |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death. |  | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of prostate<br><br>ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) metastatic involve- ment of bones and<br>DUE TO (c) visceral organs.<br><br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. |                                       |   |  |   |   | INTERVAL BETWEEN ONSET AND DEATH<br>6 moe<br><br>3 moe                           |  |
| 19a. DATE OF OPERATION 9-15-53  |  | 19b. MAJOR FINDINGS OF OPERATION as above  |                                       |   |  |   |   | 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? 177X   |  |   |   |  |  |
| 22. I hereby certify that I attended the deceased from Aug 17, 1953, to Nov 15, 1953, that I last saw the deceased alive on Nov 15, 1953, and that death occurred at 10:40 P.M., from the causes and on the date stated above.  |  |  |                                       |   |  |   |   |  |  |
| 23a. SIGNATURE George A. O'Sullivan, M.D.   |  |  |                                       | 23b. ADDRESS 217 N. Schirmer St. St. Louis, Mo.   |  | 23c. DATE SIGNED Nov. 16-53   |   |  |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Removal   |  | 24b. DATE 11/18/53   |                                       | 24c. NAME OF CEMETERY OR CREMATORY Assumption Cemetery  |  | 24d. LOCATION (City, town, or county) (State) Mattese, Mo.  |   |  |  |
| DATE REC'D BY LOCAL REG. NOV 17 1953  |  | REGISTRAR'S SIGNATURE J. Earl Smith, M.D.  |                                       |   | 25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS Fendler Und, Co. 7420 Michigan Ave. |   |   |  |  |

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

*Dr P Sullivan*

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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.....  
Signature of Student Embalmer

Signed *W. G. Peterson*.....

Licensed Embalmer No. *3767*.....

P. O. Address *7420 Michigan*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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