

FILED APR 11 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 9718  
2847

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Illinois b. COUNTY Clay	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.		c. LENGTH OF STAY (In this place) 27 days	c. CITY OR TOWN Clay City
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis Childrens		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or Print) Frank Lynn Heldebrand		4. DATE OF DEATH (Month) (Day) (Year) 3-28-55	
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married	8. DATE OF BIRTH 1-27-55
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		9b. KIND OF BUSINESS OR INDUSTRY None	9. AGE (In years last birthday) 2
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and State or Foreign Country) Illinois
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Gerald A. Heldebrand	
13b. MOTHER'S MAIDEN NAME Floretta Vail		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) No.		16. SOCIAL SECURITY NO. Nil.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS J. Johnston 500 So. Kingshighway
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) Bronchitis letis ANTECEDENT CAUSES DUE TO (b) Broncho pneumonia DUE TO (c) Tracheotomy II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Micrognathia	
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? 7586		22. I hereby certify that I attended the deceased from 3-1-1955, to 3-28-1955, that I last saw the deceased alive on 3-28-1955 and that death occurred at 9:15 p.m., from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) Dr. J. Johnston		23b. ADDRESS 500 S. Kingshighway	
23c. DATE SIGNED 3-28-55		24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	
24b. DATE 3-29-55		24c. NAME OF CEMETERY OR CREMATORY Local	
24d. LOCATION (City, town, or county) (State) Clay City, Illinois		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe 4700 Washington.	
DATE REC'D BY LOCAL REG. MAR 29 1955		REGISTRAR'S SIGNATURE [Signature]	

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

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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 *Elmer K. Padwell*

Licensed Embalmer No. *407*

P. O. Address *St. Louis*

- 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.