

FILED AUG 9 - 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

21637

State File No.

BIRTH NO. _____		REG. DIST. NO. <u>93</u>		PRIMARY REG. DIST. NO. <u>4153</u>		Registrar's No. <u>55-63</u>	
1. PLACE OF DEATH a. COUNTY <u>Dade</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>M</u> b. COUNTY <u>Dade</u>			
b. CITY (If outside corporate limits, write RURAL and give town) <u>Lockwood Mo</u>		c. LENGTH OF STAY (in this place) <u>17da</u>		c. CITY OR TOWN <u>Lockwood Mo</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Memorial Hospital</u>				STREET ADDRESS (If rural, give location) <u>Rural Grant Twp.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Eddie</u> b. (Middle) <u>Lee</u> c. (Last) <u>Heide</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>July 29 1955</u>				
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>March 30.1885</u>	
9. AGE (in years last birthday) <u>70</u>		IF UNDER 1 YEAR Months <u>3</u> Days <u>29</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Fulton Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>usa</u>	
13a. FATHER'S NAME <u>John Heide</u>			13b. MOTHER'S MAIDEN NAME <u>Almira Campbell</u>			14. NAME OF HUSBAND OR WIFE <u>Mable Heide</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>495-40-5586</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mable Heide Lockwood Mo rt3</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, asthenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute myocardial infarction</u> INTERVAL BETWEEN ONSET AND DEATH <u>17 days</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ <u>4201</u> 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				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) (m.)		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 <u>7-12-</u> , 19 <u>55</u> , to <u>7-29-</u> , 1955, that I last saw the deceased alive on <u>7-24-</u> , 19 <u>55</u> , and that death occurred at <u>10:35pm.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>Max Heilbrunn M.D.</u>				23b. ADDRESS <u>Lockwood, Mo</u>		23c. DATE SIGNED <u>8-1-55</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Aug 2 1955</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Green Lawn</u>		24d. LOCATION (City, town, or county) (State) <u>Kansas City Mo.</u>	
DATE REC'D BY LOCAL REG. <u>8-2-55</u>		REGISTRAR'S SIGNATURE <u>J. C. Canada 478-</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>W.R. Allison Greenfield Mo.</u>			

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 *W.R. Allison*.....

Licensed Embalmer No. *440*

P. O. Address *Greenville*

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.