

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **34820**
9013
Registrar's No.

FILED NOV 15 1955

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hospital		e. STREET ADDRESS (If rural, give location) 2 6606 Elmer Ave	

3. NAME OF DECEASED (Type or Print) a. (First) Louisa b. (Middle) c. (Last) Heidel	4. DATE OF DEATH (Month) (Day) (Year) 10-14-1955
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH 4-22-1863	9. AGE (In years last birthday) 92	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Joseph Jennwein	13b. MOTHER'S MAIDEN NAME Elizabeth Hervat	14. NAME OF HUSBAND OR WIFE Charles J. Heidel (Deceased)
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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. None	17. INFORMANT'S SIGNATURE OR NAME Metta Heidel	ADDRESS 6606 Elmer Ave
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 20 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage		
	ANTECEDENT CAUSES As for conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cardio-Vascular Disease Arterio-Sclerosis DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 4221			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from Sept 24, 1954, to Oct 14, 1954, that I last saw the deceased alive on Oct 14, 1954, and that death occurred at 12:10 P.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) H. Bachmayer M.D.	23b. ADDRESS 6814 Gravois Ave	23c. DATE SIGNED 10/15/55
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 10-17-1955	24c. NAME OF CEMETERY OR CREMATORY New St. Marcus Cemetery	24d. LOCATION (City, town, or county) (State) 7901 Gravois Ave Mo
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DATE REC'D BY LOCAL REG. OCT 17 1955	REGISTRAR'S SIGNATURE J. Earl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Ernest H. Biezenheim	ADDRESS 6409 Gravois Ave
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S.P. (Licensed Embalmer - Statement on Reverse Side)

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

300
48

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..... *Yau M. Szeun*

Licensed Embalmer No. *434*

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.