

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **37581**FILED NOV 16 1955 REG. DIST. NO. 242 PRIMARY REG. DIST. NO. 5830 Registrar's No. 6

1. PLACE OF DEATH a. COUNTY <u>New Madrid</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>New Madrid</u>	
b. CITY OR TOWN <u>Matthews Rural</u> c. LENGTH OF STAY (in this place) <u>26 yrs.</u>		c. CITY OR TOWN <u>Matthews</u> d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Home</u>		e. STREET ADDRESS (If rural, give location) _____	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Oscar</u> b. (Middle) <u>L.</u> c. (Last) <u>Heldenbrand</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>10</u> <u>18</u> <u>1955</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 4, 1880</u>	9. AGE (In years last birthday) <u>75</u>	10. UNDER 1 YEAR Months <u>4</u> Days <u>14</u> Hours _____ Min. _____
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>La Vera, Ill.</u>	
13a. FATHER'S NAME <u>Fernand Heldenbrand</u>		13b. MOTHER'S MAIDEN NAME <u>Harriet Rhodes</u>		14. NAME OF HUSBAND OR WIFE <u>Leatrice Heldenbrand</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____ (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Leatrice Heldenbrand Matthews, Mo</u> ADDRESS _____	

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.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>metastatic carcinoma</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Carcinoma of throat</u>			
		DUE TO (c) _____			
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>148X</u>			

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? _____	

22. I hereby certify that I attended the deceased from 4:24 1950, to Oct 18, 1955, that I last saw the deceased alive on Oct 18, 1955, and that death occurred at 1:00 p. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Win. C. Critchlow M.D.</u>		23b. ADDRESS <u>Sikeston, Mo</u>		23c. DATE SIGNED <u>Nov 1, 1955</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		24b. DATE <u>10-19-1955</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Matthews Cemetery, Matthews, Mo.</u>	
24d. LOCATION (City, town, or county) (State) _____		24e. DATE REC'D BY LOCAL REG. <u>11-5-55</u>		24f. REGISTRAR'S SIGNATURE <u>Kathryn L. McG. Bain</u>	

24d. LOCATION (City, town, or county) (State) _____		24e. DATE REC'D BY LOCAL REG. <u>11-5-55</u>		24f. REGISTRAR'S SIGNATURE <u>Kathryn L. McG. Bain</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Albritton Funeral Home - Sikeston, Mo.</u>		ADDRESS _____		_____	

(Licensed Embalmer's Statement on Reverse Side)

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

0720

0720

Mo.

DEC 8 1955

DATE RECEIVED NOV 15 1955
NEW MADRID CO. HEALTH CENTER
P. J. L.

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 [Handwritten Signature]
Licensed Embalmer No. [Handwritten Number]
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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.