

FILED DEC 13 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 39249

| | | | | | | | | | |
|---|---|--|--|---|--|---|--|---|--|
| BIRTH NO. _____ | | REG. DIST. NO. 317 | | PRIMARY REG. DIST. NO. 590 | | Registrar's No. 2699 | | | |
| 1. PLACE OF DEATH a. COUNTY ST. LOUIS | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI | | | | b. COUNTY ST. LOUIS | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN VALLEY PARK | | c. LENGTH OF STAY (In this place) 3 yrs. | | c. CITY OR TOWN OAKVILLE | | 4. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | |
| d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION MOLL NURSING HOME | | | | e. STREET ADDRESS (If rural, give location) RR # 11, BOX 270 | | | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) GERTRUDE | | | b. (Middle) JESSIE | | c. (Last) HECKEL | | 4. DATE OF DEATH (Month) (Day) (Year) NOVEMBER 16, 1955 | | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER MARRIED | | 8. DATE OF BIRTH AUGUST 24, 1876 | | 9. AGE (In years last birthday) 79 | IF UNDER 1 YEAR Months Days | IF UNDER 6 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physiotherapist | | | 10b. KIND OF BUSINESS OR INDUSTRY Therapist | | 11. BIRTHPLACE (City and State or Foreign Country) BELLEVILLE, ILLINOIS | | 12. COUNTRY OF WHAT COUNTRY? U.S.A. | | |
| 13a. FATHER'S NAME GUSTAVE HECKEL | | | 13b. MOTHER'S MAIDEN NAME SARAH LINFORD | | | 14. NAME OF HUSBAND OR WIFE NONE | | | |
| 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 ADDRESS WALTER KRUEGER RR #1, BOX 270 LEMAY 23 MO. | | | | | |
| 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, asthma, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Aortic dilatation | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 day | | |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Ch. Myocarditis | | | | | | 3 yrs | | |
| | DUE TO (c) Debility | | | | | | 5 yrs | | |
| | 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 4222 | | | | | | 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 6-1 1955, to 11/16/ 1955, that I last saw the deceased alive on 11/15, 1955, and that death occurred at 3:30 p.m., from the causes and on the date stated above. | | | | | | | | | |
| 23a. SIGNATURE (Degree or title) W. H. Sheslie, M.D. | | | | 23b. ADDRESS Ridgwood, Mo. | | | 23c. DATE SIGNED 11/17/55 | | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) | | 24b. DATE NOV. 18, 1955 | 24c. NAME OF CEMETERY OR CREMATORY WALNUT HILL CEMETERY | | 24d. LOCATION (City, town, or county) (State) BELLEVILLE, ILLINOIS | | | | |
| DATE REC'D BY LOCAL REG. 11-19-55 | | REGISTRAR'S SIGNATURE Herbert R. Lombard | | 25. FUNERAL DIRECTOR'S SIGNATURE C. HOFFMEISTER U. & L. CO. | | ADDRESS 7814 SO. BROADWAY ST. LOUIS, MO. | | | |

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

(Licensed Embalmer's Statement on Reverse Side)

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 *Harry J. Schunacker*
Licensed Embalmer No. 2679

P. O. Address *2814 S. Broadway*

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.