

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED DEC 28 1955

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 5161

1. PLACE OF DEATH
a. COUNTY Jackson

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri b. COUNTY Jackson

b. CITY (If outside corporate limits, write RURAL and give township)
OR TOWN Kansas City

c. CITY OR TOWN Kansas City

d. Is Residence within limits of a city or incorporated town?
Yes No

d. FULL NAME OF HOSPITAL OR INSTITUTION
Research Hospital

STREET ADDRESS (If rural, give location)
3707 Madison Avenue

3. NAME OF DECEASED
a. (First) Aimee b. (Middle) Grace c. (Last) HEINERIKSON

4. DATE OF DEATH (Month) (Day) (Year)
11 26 55

5. SEX
Female

6. COLOR OR RACE
White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)
Married

8. DATE OF BIRTH
Oct. 10, 1892

9. AGE (In years last birthday) Months Days Hours Min.
63

10a. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired)
Housewife

10b. KIND OF BUSINESS OR INDUSTRY
Home

11. BIRTHPLACE (City and State or Foreign Country)
Hastings, Nebraska

12. CITIZEN OF WHAT COUNTRY?
USA

13a. FATHER'S NAME
Thomas Farrell

13b. MOTHER'S MAIDEN NAME
Elizabeth J. Kennedy

14. NAME OF HUSBAND OR WIFE
Joseph J. Heinerikson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)
No

16. SOCIAL SECURITY NO.
None

17. INFORMANT'S SIGNATURE OR NAME ADDRESS
Mrs. Dorothy Heinerikson, 5036 Park

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) Spinal Decompression
ANTECEDENT CAUSES DUE TO (b) Arterial Hypotension
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) Perforated Duodenal Ulcer
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Peritonitis

INTERVAL BETWEEN ONSET AND DEATH
2 weeks
48 hours
48 hours
5 1/2 48 hours

19a. DATE OF OPERATION
11-24-55

19b. MAJOR FINDINGS OF OPERATION
Perforated Duodenal Ulcer

20. AUTOPSY?
YES NO

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 NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-24, 1955, to 11-26, 1955, that I last saw the deceased alive on 11-26, 1955, and that death occurred at 3:00 P. m., from the causes and on the date stated above.

23a. SIGNATURE Cary R. Ferris (Degree or title) MD

23b. ADDRESS 535 Argyle Bldg Kansas City, Mo.

23c. DATE SIGNED 11-28-55

24a. BURIAL, CREMATION, REMOVAL (Specify)
Burial

24b. DATE
11-29-55

24c. NAME OF CEMETERY OR CREMATORY
Mount Olivet Cemetery

24d. LOCATION (City, town, or county) (State)
Kansas City, Missouri

DATE REC'D BY LOCAL REG. REGISTRAR'S SIGNATURE
11-28-55 Alva Marshall

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
Melody-McGilley-Eylar, 1800 E. Linwood

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

Dr. Car
A. J. J.
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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 *James E. Fackler*

Licensed Embalmer No. *451*
P. O. Address *R. O. G.*

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.