

Health, Welfare, Public Service, 00 56, diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED NOV 15 1956

34024

STATE FILE NUMBER

46333

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>D.O.A. St. Mary's</b>				Length of stay in lbs <b>8 yrs</b>		d. STREET ADDRESS <b>4312 Fairmount</b> (If outside, give location)		Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>FRANK</b>			First <b>J.</b>		Middle <b>HEILING</b>		Last	
4. DATE OF DEATH <b>10 25 56</b>		Month <b>10</b>		Day <b>25</b>		Year <b>56</b>		
5. SEX <b>Ma</b>		6. COLOR OR RACE <b>Wh</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2-26-1889</b>		
9. AGE (In years last birthday) <b>67</b>		IF UNDER 1 YEAR Months <b>67</b>		IF UNDER 24 HRS. Days <b>67</b>		Hours <b>67</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret.</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (City and state or country) <b>Kansas City, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Frank J. Heiling</b>				14. MOTHER'S MAIDEN NAME <b>Mary Kohler</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>561-07-0990</b>		17. INFORMANT <b>Francis Miller, 4312 Fairmount</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Arteriosclerosis</b> DUE TO (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH <b>4200</b>	
20a. ACCIDENT <input type="checkbox"/>		SUICIDE <input type="checkbox"/>		HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____								
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE		
21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at <b>5:30 P.M.</b> _____ m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <b>Geo. C. Kealhofer</b> (Degree or title)			22b. ADDRESS <b>6627 Proctor St</b>			22c. DATE SIGNED <b>10-26-56</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10-27-56</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. St. Mary's</b>		23d. LOCATION (City, town, or county) (State) <b>Kansas City, Mo.</b>		
24. FUNERAL DIRECTOR <b>Wagner Funeral Home</b> ADDRESS <b>K C Mo</b>		25. DATE RECD. BY LOCAL REG. <b>10-26-56</b>		26. REGISTRAR'S SIGNATURE <b>Neva Minshall</b>				

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION  
Geo. C. Kealhofer

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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 *Alvin R. Hansen*

Licensed Embalmer No. *4*

P. O. Address *R. E.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.  
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.