

Health & Welfare  
Public Service

300  
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED MAY 7 - 1957

STANDARD CERTIFICATE OF DEATH

12721

STATE FILE NUMBER

Registration District No. 119 Primary Registration District No. 5436 Registrar's No. 13

1. PLACE OF DEATH a. COUNTY Gasconade				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Gasconade			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Bay		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Bay		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Residence			Length of stay in 1b lifetime	d. STREET ADDRESS none (If outside, give location)			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Samuel Heilert				4. DATE OF DEATH April 25, 1957 Month Day Year			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-6-1872	9. AGE (In years last birthday) 84	IF UNDER 1 YEAR Months Day Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer			10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (City and state or country) Bay, Mo.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME August Heilert				14. MOTHER'S MAIDEN NAME Caroline Nullmeyer			
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 Address Mrs. Helen Heilert Bay, Mo.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Arterial Sclerosis - Arterial Sclerotic Heart Disease</i>						INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Branchial Cyst - Recent</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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 Month, Day, Year 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 <i>4:00 p.m.</i> to <i>4-25-57</i> and last saw <i>him</i> alive on <i>4-21-57</i> . Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <i>Clara Schubert</i>				22b. ADDRESS <i>Bay, Mo.</i>		22c. DATE SIGNED <i>4-27-57</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 4-29-1957	23c. NAME OF CEMETERY OR CREMATORY Bethel Presbyterian Cem.		23d. LOCATION (City, town, or county) Bay, Mo.		(State)	
24. FUNERAL DIRECTOR <i>Milford H. Winter</i>			ADDRESS OWENSVILLE	25. DATE RECD. BY LOCAL REG. 4-28-57	26. REGISTRAR'S SIGNATURE <i>Delma Gerken</i>		

(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.....  
*Michael H. Winter*

Licensed Embalmer No. 3838

P. O. Address D.W.F. 5014

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.