

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

31366

FILED SEP 25 1957

STATE FILE NUMBER 632

Registration District No. 113 Primary Registration District No. 5431 Registrar's No.

1. PLACE OF DEATH a. COUNTY <b>FRANKLIN</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>FRANKLIN</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ROBERTSVILLE Mo</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <b>ROBERTSVILLE</b> 0360 Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Length of stay in 1b		d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>MICHAEL HEILICH</b>			4. DATE OF DEATH Month Day Year <b>SEPT 18 1957</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</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>MAR 2, 1969</b>
9. AGE (In years last birthday) <b>88</b>		IF UNDER 1 YEAR Month <b>88</b> Days <b>12</b> Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>PLANING MILL</b>	11. BIRTHPLACE (City and state or country) <b>AUSTRIA HUNGARY</b>
13. FATHER'S NAME <b>PETER HEILICH</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>486-22-2639A</b>	17. INFORMANT Address <b>JOHN HEILICH ROBERTSVILLE Mo</b>
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>Senile &amp;therosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>ONE YEAR</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>General Arteriosclerosis</b>			<b>YEARS-</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>4.500</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>3</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 Month, Day, Year a. m. p. m.			
20d. INJURY OCCURRED WHILE AT <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 <b>Aug-30-'57</b> to <b>9-18-57</b> and last saw <sup>her</sup> him alive on <b>9-16-57</b> . Death occurred at <b>9-14-57</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Dr. W. E. Kitchell M.D.</b>		22b. ADDRESS <b>Sp. Clairmo</b>	22c. DATE SIGNED <b>9-18</b>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <b>Sept 26, 1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>RESURRECTION CEMETERY</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis Co Mo</b>
24. FUNERAL DIRECTOR <b>KRIEGSHAUSER</b> ADDRESS <b>4228 S KINGSTON</b>	25. DATE RECD. BY LOCAL REG. <b>9/18-57</b>	26. REGISTRAR'S SIGNATURE <b>Aloyd Williams</b>	

OCT 16 1957

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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 e  
by me, or by ....., Student Embalmer No.....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Richard W. Stone*.....

Licensed Embalmer No...4

P. O. Address .....

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.