

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35866

STATE NUMBER

FILED NOV 14 1957

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5024

300
1-57

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Ray</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Concordia</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) <u>Trinity Lutheran</u> HOSPITAL OR INSTITUTION		Length of stay in 1b <u>2 days</u>	d. STREET ADDRESS (If outside, give location) <u>119 Main St</u>	
3. NAME OF DECEASED (Type or print) First <u>GUSTAV</u> Middle <u>HEERMANN</u> Last <u>HEERMANN</u>			4. DATE OF DEATH Month <u>Oct</u> Day <u>28</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 14, 1880</u>	
9. AGE (In years last birthday) <u>77</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Furniture Clerk</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Furniture Store</u>	11. BIRTHPLACE (City and state or country) <u>Emma Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13a. FATHER'S NAME <u>Henry Heermann</u>		13b. MOTHER'S MAIDEN NAME <u>Maria Diers</u>	14. NAME OF HUSBAND OR WIFE <u>* Flora</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT Address <u>Mrs John Hartwig Concordia Mo.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2-3 days</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>arteriosclerosis of cerebral arteries</u>	DUE TO (c) <u> </u>	332X	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Diabetes Mellitus</u>			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 <u> </u> Month <u> </u> Day <u> </u> Year <u> </u> a.m. <u> </u> p.m. <u> </u>	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 <u> </u> STATE <u> </u>	
21. I attended the deceased from <u>10-26-57</u> to <u>10-28-57</u> and last saw her <u>live on</u> <u>10-28-57</u> Death occurred at <u>5:45</u> P on the date stated above; and to the best of my knowledge, from the causes stated.				
22a. SIGNATURE <u>John W. Cashman</u> (Degree or title)		22b. ADDRESS <u>535 Argyle Bldg K Mo</u>		22c. DATE SIGNED <u>10/25/57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>Oct 30, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St Pauls Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Concordia Missouri</u>	
24. FUNERAL DIRECTOR <u>James Funeral Home Concordia Mo.</u>		ADDRESS	25. DATE RECD. BY LOCAL REG. <u>10-29-57</u>	26. REGISTRAR'S SIGNATURE <u>neva minshall</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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.

John W. Cashman



JAN 4 1963

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 *Chas. E. Walks*

Licensed Embalmer No. *2644*

P. O. Address: *J. E. M. O.*

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.