

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39001
STATE FILE NUMBER

FILED OCT 24 1957

Registration District No. 378 Primary Registration District No. 4552 Registrar's No. 50

S. 300
7-1-57
1141
9

1. PLACE OF DEATH a. COUNTY <i>Wright</i>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Wright, Mo.</i>			c. CITY OR TOWN <i>Wright, Mo.</i>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION			d. STREET ADDRESS (If outside, give location)		
3. NAME OF DECEASED (Type or print) First Middle Last <i>LOUISA EUGENIA HEEFFINGTON</i>			4. DATE OF DEATH Month Day Year <i>OCT 18, 1957</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 28, 1868</i>		9. AGE (In years last birthday) <i>89</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housekeeper</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <i>Burney, Mo.</i>	
13a. FATHER'S NAME <i>T. G. Davis</i>		13b. MOTHER'S MAIDEN NAME <i>Arsustina Davis</i>		14. NAME OF HUSBAND OR WIFE <i>W. H. Heffington</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give name of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>no</i>		17. INFORMANT <i>Mrs. America Childs</i>	
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>Coronary Arteriosclerosis</i>					INTERVAL BETWEEN ONSET AND DEATH <i>10-18-57</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Arteriosclerosis, Hypertension, Coronary Arteriosclerosis</i>					<i>Not known</i>
DUE TO (c) _____					<i>Not known</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>4201</i>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT - SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 <i>Jan 1950</i> to <i>Oct 18 1957</i> and last saw her/him alive on <i>Oct 14 1957</i> Death occurred at <i>7:00 A.M.</i> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <i>W. H. Connor, M.D.</i>			22b. ADDRESS <i>Mountain View, Mo.</i>		22c. DATE SIGNED <i>10-19-57</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		23b. DATE <i>10-20-57</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Burney</i>		23d. LOCATION (City, town, or county) (State) <i>Burney Mo</i>
24. FUNERAL DIRECTOR ADDRESS <i>Stable Winds, Mt. View, Mo.</i>			25. DATE RECD. BY LOCAL REG. <i>10-19-57</i>		26. REGISTRAR'S SIGNATURE <i>A. E. Amos</i>

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.

(To be filled in by the Embalmer's Statement on Reverse Side)

RECEIVED / 6-2-57
WRIGHT CO. HEALTH DEPT.
County File Number / 0-3-0-57
Date Filed

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 *Frank Grable*

Licensed Embalmer No. *4140*

P. O. Address *52th Grove, Mo*

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.