

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JAN 30 1958

State File No. **3019**
Registrar's No. **871**

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		State File No. 3019		Registrar's No. 871	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY _____					
b. CITY (If outside corporate limits, write RURAL and give town or township) St. Louis		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 01 5040 Beacon Ave.				STREET ADDRESS (If rural, give location) 5040 Beacon Ave.					
3. NAME OF DECEASED (Type or Print)		a. (First) BARBARA		b. (Middle) _____		c. (Last) HEIDEMANN		4. DATE OF DEATH (Month) (Day) (Year) Jan. 23 1958	
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH Apr. 22 1881		9. AGE (In years last birthday) 76	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 2 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (City and State or Foreign Country) Rumania		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13a. FATHER'S NAME Peter Krastl			13b. MOTHER'S MAIDEN NAME Not Known			14. NAME OF HUSBAND OR WIFE Kasper Heidemann			
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'S SIGNATURE OR NAME ADDRESS Kasper Heidemann 5040 Beacon Ave.					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic myocarditis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Coronary thrombosis DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 420.1							INTERVAL BETWEEN ONSET AND DEATH 1 MO.	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____						20. AUTOPSY? 2 YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____					
22. I hereby certify that I attended the deceased from 12-23 , 19 57 , to 1-23 , 19 58 , that I last saw the deceased alive on 1-23 , 19 58 , and that death occurred at 4:30 p.m. , from the causes and on the date stated above.									
23a. SIGNATURE G. W. Knapp D.O.				(Degree or title) _____		23b. ADDRESS 4991 7th St		23c. DATE SIGNED 1/24/58	
24a. BURIAL, CREMATION, REMOVAL (Specify) burial		24b. DATE 1/27/58		24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis Mo.			
DATE REC'D BY LOCAL REG. JAN 24 '58		REGISTRAR'S SIGNATURE J. Earl Smith M.D.			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Buchholz Mortuary 5967 W. Florissant Ave.				

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 *Walter A. Bralton*.....

Licensed Embalmer No. *455*.....

P. O. Address *Adrian*.....

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.