

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-017503

STATE FILE NUMBER

Registration District No. 53 Primary Registration District No. \_\_\_\_\_ Registrar's No. 339

1. PLACE OF DEATH a. COUNTY <u>Cape Girardeau</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cape Girardeau</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Cape Girardeau</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Cape Girardeau</u> <sup>0104</sup> 0
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Southeast Mo. Hospital</u>		Length of stay in lb <u>3 days</u>	d. STREET ADDRESS (If outside, give location) <u>1028 West Cape Rock Dr.</u>
3. NAME OF DECEASED (Type or print) First <u>WALTER</u> Middle <u>C.</u> Last <u>HEIMBAUGH</u>			4. DATE OF DEATH Month <u>May</u> Day <u>27</u> Year <u>1958</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>July 15, 1888</u>
9. AGE (In years last birthday) <u>69</u>		IF UNDER 1 YEAR Months <u>10</u> Days <u>12</u>	IF UNDER 24 HRS. Hours <u>12</u> Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter, ret.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Contractor</u>	11. BIRTHPLACE (City and state or country) <u>Houston, Illinois</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>		13a. FATHER'S NAME <u>Albert Heimbaugh</u>	
13b. MOTHER'S MAIDEN NAME <u>Ella Mc Mans</u>		14. NAME OF HUSBAND OR WIFE <u>Ruby F. Heimbaugh</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>496-14-4171</u>	17. INFORMANT <u>Mrs. Ruby F. Heimbaugh</u> Address <u>Cape Gir., 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>Acute myocardial infarction</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Coronary artery disease.</u> DUE TO (c) <u>4201</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hr.</u> <u>2 1/2 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Congestive heart failure.</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 _____ Month, Day, Year _____ a.m. _____ p.m. _____		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>11-28-55</u> to <u>5-27-58</u> and last saw her/him live on <u>5-26-58</u> Death occurred at <u>6:35 a.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Charles E. Wilson M.D.</u>		22b. ADDRESS <u>714 Bealway Cape Girardeau, Mo.</u>	
22c. DATE SIGNED <u>5-27-58</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>May 29, 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Cape Girardeau, Missouri</u>
24. FUNERAL DIRECTOR <u>Walters Funeral Home</u>		ADDRESS <u>Cape Gir.</u>	25. DATE RECD. BY LOCAL REG. <u>May 5, 1958</u>
26. REGISTRAR'S SIGNATURE <u>Mrs. Homer C. Cooper</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.

SEP 23 1958

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 *Virgil H. Kelch* .....  
Licensed Embalmer No. *4192* .....  
P. O. Address *Cape Swarden* .....

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.