

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-017846

STATE FILE NUMBER

FILED JUN 2 1958 Registration District No. 128 Primary Registration District No. 200 Registrar's No. 528B

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Iowa</u> b. COUNTY <u>Marshall</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Marshalltown</u> <u>81408</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Medical Center for Federal Prisoners</u> Length of stay in 1b <u>47 days</u>		d. STREET ADDRESS (If outside, give location) <u>R.F.D. #2</u> Reside on Form Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Stanton</u> Middle <u>Lowell</u> Last <u>Heuer</u>			4. DATE OF DEATH Month <u>May</u> Day <u>20</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>3-25-1910</u>	9. AGE (In years last birthday) <u>48</u>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck business</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Trucking</u>	11. BIRTHPLACE (City and state or country) <u>Marshalltown, Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Anthony Heuer (deceased)</u>			14. MOTHER'S MAIDEN NAME <u>Mary Lapour (deceased)</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year, or dates of service) <u>Yes</u> <u>1942-44</u>		16. SOCIAL SECURITY NO. <u>443-14-8072</u>	17. INFORMANT <u>Files-MCFP</u> Address _____		

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 Coronary Occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 min.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Unknown</u>		
DUE TO (c) <u>Probable Arterioscleratic Heart Disease</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>4200</u>		

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 _____ a. m. _____ p. m. _____	*****	

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 _____ STATE _____
21. The Medical Staff <u>attended the deceased from April 4, 1958 to May 20, 1958</u> and last saw <u>him</u> alive on <u>May 20, 1958</u> Death occurred at <u>5:45 P.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>J.A. Hunter M.D.</u> (Date of Issue)		22b. ADDRESS <u>Clinical Director, Medical Center for Federal Prisoners, Springfield</u>	22c. DATE SIGNED <u>5-21-58</u>

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>5-21-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Unknown</u>	23d. LOCATION (City, town, or county) (State) <u>Marshalltown, Iowa</u>
24. FUNERAL DIRECTOR <u>AYRE-GOODWIN, SPRINGFIELD, MO.</u>		25. DATE RECD. BY LOCAL REG. <u>5-26-58</u>	26. REGISTRAR'S SIGNATURE <u>Effie G. Melton</u>

(Licensed Embalmer's Statement on Reverse Side)

300  
1-56

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. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, or by ..... Student Embalmer No. ....

working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed..... *Gene C. Hunt* .....

Licensed Embalmer No. 473 .....

P. O. Address *Spalding* .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (E 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.