

FILED AUG 1 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-027038

STATE FILE NUMBER

7161

Registration District No. _____

318

Primary Registration District No. _____

1003

Registrar's No. _____

300
1-57

| | | | | | |
|---|----------------------------------|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN St. Louis | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Desloge Hospital | | Length of stay in lb 1 day | d. STREET ADDRESS (If outside, give location) 2249 2925 Missouri Ave. | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) JOSEPH B. HEINZER | | | 4. DATE OF DEATH July 18, 1958 | | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 7, 1889 | 9. AGE (In years last birthday) 69 yrs. | IF UNDER 1 YEAR Months 3 Days 11 Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman | | 10b. KIND OF BUSINESS OR INDUSTRY Retired | 11. BIRTHPLACE (City and state or country) Switzerland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. |
| 13a. FATHER'S NAME Baltazar Heinzler | | 13b. MOTHER'S MAIDEN NAME Regina Schoenbachler | | 14. NAME OF HUSBAND OR WIFE Adele Goettke | |
| 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. 493-05-5723 | 17. INFORMANT Address Delphine Heinzler 2925 Missouri Ave. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular thrombosis | | | | | INTERVAL BETWEEN ONSET AND DEATH 4 days. |
| Conditions, if any, which gave rise to above cause (a), stating the under- lying cause last. | | | | | |
| DUE TO (b) Cerebral arteriosclerosis | | | | | ? years. |
| DUE TO (c) Diabetes Mellitus | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Diabetes Mellitus | | | | | 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 <input type="checkbox"/> WORK AT WORK | | 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 Oct. 1957 , to July 18, 1958 and last saw ^{him} her alive on July 18, 1958 Death occurred at 3:00 P. on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE (Degree or title) Charles Silverberg M.D. | | | 22b. ADDRESS 462 N. Taylor Ave. | | 22c. DATE SIGNED 7/19/58 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) removal | 23b. DATE 7/22/58 | 23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery | | 23d. LOCATION (City, town, or county) (State) St. Louis County Missouri | |
| 24. FUNERAL DIRECTOR Gebken Sons | | ADDRESS 2630 Gravois Ave. | | 25. DATE RECD. BY LOCAL REG. JUL 21 '58 | 26. REGISTRAR'S SIGNATURE Carl Smith M.D. m j b. |

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.

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 *Herbert J. Gaw*

Licensed Embalmer No. *4800*

P. O. Address *Kennwood 2*

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.