

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-034310  
STATE FILE NUMBER  
9104

FILED OCT 10 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

5. 300  
1-57

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 8818 Goodfellow		d. STREET ADDRESS (If outside, give location) 8818 Goodfellow Blvd	
3. NAME OF DECEASED (Type or print) First Middle Last CRIS F. HECKER		4. DATE OF DEATH Month Day Year Sept. 18 1958	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 19, 1909
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Serviceman		10b. KIND OF BUSINESS OR INDUSTRY Elec. Repair	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Benedict Hecker		13b. MOTHER'S MAIDEN NAME Alice Revenue	14. NAME OF HUSBAND OR WIFE Kathryn Hecker
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) yes WW 2		16. SOCIAL SECURITY NO. 486 22 8502	17. INFORMANT Address Kathryn Hecker 8818 Goodfellow Blvd.
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 Atherosclerosis</i>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <i>420.1</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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. 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. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at _____ to _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Name or title) <i>James M Kelly Coronator</i>		22b. ADDRESS <i>1300 Clark</i>	22c. DATE SIGNED <i>9-22-58</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>removal</i>	23b. DATE <i>9/22/58</i>	23c. NAME OF CEMETERY OR CREMATORY <i>St. Peters Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>St. Louis County Mo.</i>
24. FUNERAL DIRECTOR ADDRESS <i>Buchholz Mortuary 5967 W. Florissant</i>		25. DATE RECD. BY LOCAL REG. <i>SEP 22 '58</i>	26. REGISTRAR'S SIGNATURE <i>J. Carl Smith, M.D.</i>

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 *Alfred A. Berchko* .....

Licensed Embalmer No. *4551*  
P. O. Address *St. Louis*

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.