

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-034312  
STATE FILE NUMBER

FILED SEP 22 1958

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 8468

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Mehlville 4840		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Lukes Hospital		Length of stay in lb 12 days	d. STREET ADDRESS (If outside, give location) 1861 Bauer Rd		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First OTTO Middle FREDERICK Last HEINICKE			4. DATE OF DEATH Month Day Year Aug. 31, 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 Feb. 20, 1921	9. AGE (In years last birthday) 37 IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) consulting engineer		10b. KIND OF BUSINESS OR INDUSTRY structural	11. BIRTHPLACE (City and state or country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Otto E. Heinicke		13b. MOTHER'S MAIDEN NAME Anna M. Schwalf		14. NAME OF HUSBAND OR WIFE LaVallon Little Heinicke	
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.	17. INFORMANT Address Mrs. LaVallon Heinicke, 1861 Bauer Rd.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Epidermoid carcinoma of bronchus with generalized metastases Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					INTERVAL BETWEEN ONSET AND DEATH 3 mos.
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 <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 9 June 58 to 31 Aug 58 and last saw him alive on 30 Aug 58 Death occurred at 4:30 AM. m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) T. G. Drake, M.D.			22b. ADDRESS 114 N. Taylor (8)		22c. DATE SIGNED 2 Sept 58
23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE Sept. 3, 1958	23c. NAME OF CEMETERY OR CREMATORY Sunset Burial Park		23d. LOCATION (City, town, or county) (State) St. Louis, County, Missouri	
24. FUNERAL DIRECTOR BEIDERWIEDEN F.H. INC., 1936 St. Louis Ave			25. DATE RECD. BY LOCAL REG. SEP 1 '58	26. REGISTRAR'S SIGNATURE J. Earl Smith, M.D.	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

300  
1-57

Doctor, coroner, etc., near cause only standard nomenclature in their reports. No symptoms will be stated. All diseases in Part I must be causally related.

Dr. Truman Drake,

114 N. Taylor St. 3-8600

Res. 6344 Alexander - PA1-4829

1 pin

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 \_\_\_\_\_

Licensed Embalmer No. 4520  
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.