Health, Welfare Public Service

300 -57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-003974
STATE FILE NUMBER

FILED FEB 16 1959

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 390

1. PLACE OF DEATH
a. COUNTY St. Louis County
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) Hathaway Hills — Inside Limits Yes ☑ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 933 Marias Dr. — Length of stay in 1b YRS

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY St. Louis Co
c. CITY OR TOWN Hathaway Hills 4020 — Inside Limits Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location) 933 Marias Dr. — Reside on Farm Yes ☐ No ☑

3. NAME OF DECEASED (Type or print) First Josephine Middle Last Heitland

4. DATE OF DEATH Month 2 Day 8 Year 59

5. SEX F

6. COLOR OR RACE W

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH 2/13/1888

9. AGE (In years last birthday) 70 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) self

10b. KIND OF BUSINESS OR INDUSTRY HOME

11. BIRTHPLACE (City and state or country) St. Louis, Mo.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME John Marren

13b. MOTHER'S MAIDEN NAME Hanorah Keenan

14. NAME OF HUSBAND OR WIFE John

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. —

17. INFORMANT Mr. John Heitland Address 933 Marias Dr.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH 2 yrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Carcinoma of the Colon — 6 yrs.
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 1538

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE 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 10-28-49, to Feb. 7-59 and last saw her/him alive on Feb-7-59
Death occurred at 5.15 P.M. in on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Gaspose Scorthup MD

22b. ADDRESS 9279 Bataan Dr.

22c. DATE SIGNED 2/9/59

23a. BURIAL, CREMATION, REMOVAL (State) Burial

23b. DATE 2/11/59

23c. NAME OF CEMETERY OR CREMATORY Calvary

23d. LOCATION (City, town, or county) (State) St. Louis Mo

24. FUNERAL DIRECTOR Jos. A. Howard ADDRESS 1619 So. Grand

25. DATE RECD. BY LOCAL REG. 2-9-59

26. REGISTRAR'S SIGNATURE John C. Murphy MD

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 Stanley H. Sirion

Licensed Embalmer No. 4193

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.