

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-008836

STATE FILE NUMBER

MAR 23 1959

Registration District No.

77

Primary Registration District No.

5304

Registrar's No.

88

1. PLACE OF DEATH a. COUNTY COLE b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN WARDSVILLE MO. c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION R R # 4 J C MO.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY COLE c. CITY OR TOWN WARDSVILLE, MO. d. STREET ADDRESS RR # 4 J C MO.	
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3. NAME OF DECEASED (Type or print) First ANTON Middle HECKMAN Last	4. DATE OF DEATH Month MARCH Day 18 Year 1959
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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 July 6, 1884	9. AGE (In years last birthday) 74 IF UNDER 1 YEAR Months 8 Days 12 IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FARMER	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) WESTPHALIA, MO.	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME BALT HECKMAN	13b. MOTHER'S MAIDEN NAME ELIZABETH KAMPMAN	14. NAME OF HUSBAND OR WIFE ANNA FRANK
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT Address MRS. ANNA HECKMAN WARDSVILLE, MO.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism 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) Fracture neck of femur 1-12-59.	INTERVAL BETWEEN ONSET AND DEATH 10 min.
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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.)
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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 WARDSVILLE COUNTY STATE
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21. I attended the deceased from Jan. 12, 1959 to Mar. 18, 1959 and last saw her/him alive on Mar. 14, 1959 Death occurred at 7:15 P m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) R. P. Darris, M.D.	22b. ADDRESS Jefferson City, Mo.	22c. DATE SIGNED 3-20-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 3/21/59	23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus	23d. LOCATION (City, town, or county) Wardsville, Mo. (State)
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24. FUNERAL DIRECTOR Address J C MO.	25. DATE RECD. BY LOCAL REG. 21 March 1959	26. REGISTRAR'S SIGNATURE R. P. Darris, M.D. - M.R.
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1-57

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.

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 embalmed by me, or by, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Sylvester Dulle*

Licensed Embalmer No. *4321*

P. O. Address *Duffield*

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.