

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011001

STATE FILE NUMBER

2 2072

MAR 17 1959 Registration District No. Primary Registration District No. Registrar

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY	
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 Chronic		d. STREET ADDRESS (If outside, give location) 2030 Gano	
3. NAME OF DECEASED (Type or print) John Heidebur		4. DATE OF DEATH Month 2 Day 26 Year 59	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/12/1874
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Wagner Electric		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) St. Louis
13a. FATHER'S NAME John H Heidebur		13b. MOTHER'S MAIDEN NAME Mary Depenbrock	14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT Mannie Koester Address 2030 Gano
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Arterio Sclerosis Fracture of Right Hip. 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) E904-20			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT <input checked="" 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.) Suffered in fall at home, etc		
20c. TIME OF INJURY Hour 12 Month 4 Day 58 Year 2009 a.m. p.m.	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, etc.) Home		
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20f. CITY, TOWN, OR LOCATION St Louis Mo		
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at 1245 A on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Patrick Taylor Carver (Degree or title)		22b. ADDRESS 1300 Clark	
22c. DATE SIGNED 2.27.59			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2/28/59	23c. NAME OF CEMETERY OR CREMATORY Calvary	23d. LOCATION (City, town, or county) (State) St. Louis Mo.
24. FUNERAL DIRECTOR ST. LOUIS FUNERAL HOME 2205 ST. LOUIS AVE.		25. DATE RECD. BY LOCAL REG. FEB 27 '59	26. REGISTRAR'S SIGNATURE Paul Smith, M.D.

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 *Robert M. Mirra*

Licensed Embalmer No.

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.