

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-013823

STATE FILE NUMBER

FILED APR 29 1959

Registration District No. 163

Primary Registration District No. 3031

Registrar's No. 36

300
-57

1. PLACE OF DEATH a. COUNTY JEFF.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY JEFF.	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN DESOTO		c. CITY OR TOWN De Soto	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 515 JEFFERSON		d. STREET ADDRESS (If outside, give location) 515 JEFFERSON	
3. NAME OF DECEASED (Type or print) First JAMES Middle WARREN Last HEFFRON		4. DATE OF DEATH Month APR. Day 19 Year 1959	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 23 1880
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET. CARPENTER		11. BIRTHPLACE (City and state or country) BELGRADE Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME OSCAR HEFFRON		13b. MOTHER'S MAIDEN NAME FRANCES HAWKINS	14. NAME OF HUSBAND OR WIFE BESSIE HEFFRON
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. UNK.	17. INFORMANT BESSIE HEFFRON Address 575 JEFFERSON DE SOTO MO.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Disease			INTERVAL BETWEEN ONSET AND DEATH 6 yrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) moderate hypertension - Valvular Dis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (but not related to the terminal disease condition given in PART I (a)) 42c1			
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 _____ a.m. _____ p.m.		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 8-18-58 to 4-19-59 and last saw ^{him} alive on 4-18-59 Death occurred at 8 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Charles E. Faller (Degree or title)		22b. ADDRESS De Soto Mo	
22c. DATE SIGNED 4-20-59			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE APR. 22 1959	23c. NAME OF CEMETERY OR CREMATORY WOODLAWN PARK	23d. LOCATION (City, town, or county) (State) De Soto Mo.
24. FUNERAL DIRECTOR V.B. PIETRICH ADDRESS De Soto Mo.		25. DATE RECD. BY LOCAL REG. April 21-1959	26. REGISTRAR'S SIGNATURE Marie Harris

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

STATE RECEIVED
MAY 25 1950

MAY 1 1950

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 *Donnell B. Dietrich*

Licensed Embalmer No. *4104*

P. O. Address *Delto Mo*

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.