

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-016116

STATE FILE NUMBER

FILED MAY 7 1959

Registration District No. 317

Primary Registration District No. 544

Registrar's No. 944

300
1-57
9
294
0

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| 1. PLACE OF DEATH a. COUNTY St. Louis | | 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 Kirkwood | | c. CITY OR TOWN St. Louis | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION White Oaks Home | | d. STREET ADDRESS 3644 Natural Bridge Fairgrounds Hotel | |
| Length of stay in lb 30 Days | | on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

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|---|--------|--|---|-------|-----|
| 3. NAME OF DECEASED (Type or print) ALBERT PETER HEUER | | | 4. DATE OF DEATH Month Day Year 4-7-1959 | | |
| First | Middle | | Last | Month | Day |

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|--------------------|------------------------------|---|---------------------------------------|--|--------------------------------|--------------------------------|
| 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 12-30-1874 | 9. AGE (In years 1st birthday) 84 | IF UNDER 1 YEAR Months Days | 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) None | 10b. KIND OF BUSINESS OR INDUSTRY None | 11. BIRTHPLACE (City and state or country) St. Louis Mo. | 12. CITIZEN OF WHAT COUNTRY? USA |
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| 13a. FATHER'S NAME Frederick Heuer | 13b. MOTHER'S MAIDEN NAME Suzette Muenchen | 14. NAME OF HUSBAND OR WIFE None |
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| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, not unknown) (If yes, give war or dates of service) No | 16. SOCIAL SECURITY NO. None | 17. INFORMANT Address Wm. H. Heuer 1414 Woodhue. Crestwood 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) Arteriosclerotic heart disease | | INTERVAL BETWEEN ONSET AND DEATH 4 ± yrs 30+ yrs 20 yrs |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) Arteriosclerosis general | |
| | DUE TO (c) Senility 420.0 | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2 |

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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 | COUNTY | STATE |
|--|---|--|------------------------------|--------|-------|

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| 21. I attended the deceased from March 10 to April 7 and last saw her alive on April 7, 1959 Death occurred at 3:45 m on the date stated above; and to the best of my knowledge, from the causes stated. |
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| 22a. SIGNATURE J. Ed. Jean M.D. (Degree or title) | 22b. ADDRESS 4500 W PINE | 22c. DATE SIGNED 4-7-59 |
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|--|----------------------------|---|---|-----------------------|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 4-8-59 | 23c. NAME OF CEMETERY OR CREMATORY St. Trinity Lutheran | 23d. LOCATION (City, town, or county) St. Louis Co. | (State) Mo. |
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| 24. FUNERAL DIRECTOR Parker-Aldrich Webster Groves Mo. | ADDRESS | 25. DATE RECD. BY LOCAL REG. 4-8-59 | 26. REGISTRAR'S SIGNATURE John C. Murphy M.D. |
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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 *Leslie Welch*

Licensed Embalmer No. *4395*

P. O. Address *White Grove*

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.