

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-023721

STATE FILE NUMBER

FILED JUN 22 1959

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1612

300
1-57

60
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1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Normandy		c. CITY OR TOWN Normandy (Township)	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION O'Sullivan Home		d. STREET ADDRESS (If outside, give location) 7090 Lexington	
3. NAME OF DECEASED (Type or print) First Middle Last EMMA JOSEPHINE HECKMANN		4. DATE OF DEATH Month Day Year June 12, 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 15, 1877
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home maker	11. BIRTHPLACE (City and state or country) Belleville, Illinois
13a. FATHER'S NAME Augustus Chenot		13b. MOTHER'S MAIDEN NAME Elizabeth Boul	14. NAME OF HUSBAND OR WIFE Frank Heckmann
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. None	17. INFORMANT Address Clarence Hasselbach 7082 Lexington
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhages Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. } DUE TO (b) Hypertensive Cardio-vascular disease DUE TO (c) unknown PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 443X			INTERVAL BETWEEN ONSET AND DEATH 5 years
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 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
21. I attended the deceased from Sept 16, 1958 to June 12, 1959 and last saw her alive on June 11, 1959 Death occurred at 4:30 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Lewie Littmann MD (Degree or title)		22b. ADDRESS 8231 Clayton Rd (17)	22c. DATE SIGNED 6-15-59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE June 15, 1959	23c. NAME OF CEMETERY OR CREMATORY St. Peters Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis County Mo.
24. FUNERAL DIRECTOR Cullen Kelly 7267 Natural Bridge		25. DATE RECD. BY LOCAL REG. 6-15-59	26. REGISTRAR'S SIGNATURE John C. Murphy MD

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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 *James A. Lammes*

Licensed Embalmer No. *4142*

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.