

# VITAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-024209

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STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Buchanan</b> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph, Missouri</b> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>State Hospital #2</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Gentry</b> c. CITY OR TOWN <b>Albany, Missouri</b> d. STREET ADDRESS (If outside, give location) <b>Rural</b>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Edith</b> Middle <b>L.</b> Last <b>Heaton</b>			<b>4. DATE OF DEATH</b> Month <b>July</b> Day <b>28</b> Year <b>1959</b>				
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input checked="" type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>(UNK) 1890</b>	<b>9. AGE (last birthday)</b> <b>about 69</b>	<b>IF UNDER 1 YEAR</b> Months _____ Days _____	<b>IF UNDER 24 HR</b> Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>At Home</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>Gentry Co., Missouri</b>		<b>12. CITIZEN OF WHAT COUNTRY</b> <b>USA</b>	
<b>13a. FATHER'S NAME</b> <b>Herbert Heaton</b>		<b>13b. MOTHER'S MAIDEN NAME</b> <b>Rachael Gibson</b>		<b>14. NAME OF HUSBAND OR WIFE</b> <b>Single</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>W. F. Heaton, Albany, Missouri</b>		<b>17. INFORMANT</b> Address _____			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Decompensated Heart</b> DUE TO (b) <b>Malnutrition</b> DUE TO (c) <b>Arteriosclerosis</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)			
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____		<b>20d. INJURY RECEIVED</b> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b>		COUNTY _____ STATE _____			
<b>21. I attended the deceased from</b> <u>7/27/1959</u> , to <u>7/28/1959</u> and last saw <sup>her</sup> <sub>him</sub> alive on <u>7/27/1959</u> Death occurred at <u>3:45 A</u> _____ m on the date stated above, and to the best of my knowledge, from the causes stated.							
<b>22a. SIGNATURE</b> (Degree or title) <b>C. E. Cassin, M.D.</b>			<b>22b. ADDRESS</b> <b>State Hospital #2</b>		<b>22c. DATE SIGNED</b> <b>1959 July 28</b>		
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Removal</b>		<b>23b. DATE</b> <b>July 28, 1959</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Albany Missouri</b>			
<b>24. FUNERAL DIRECTOR</b> <b>Heaton, Emma</b>			<b>25. DATE RECD. BY LOCAL REG.</b> <b>July 28, 1959</b>		<b>26. REGISTRAR'S SIGNATURE</b> <b>Ma. Clark Gardell</b>		

DOCUMENT

MEDICAL CERTIFICATION  
C. E. Cassin, M.D.

BY AFFIDAVIT OF

SEP 3 1959

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed William Spelling  
Licensed Embalmer No. 4038

P. O. Address St. Joseph

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.