

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-028555

FILED VS SEP 8 1959

59-71

STATE FILE NUMBER

INDEXED

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Dade		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Dade	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Lockwood Mo		c. CITY OR TOWN Lockwood Mo	
Length of stay in 1b 10yrs		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Memorial Hospital		d. STREET ADDRESS (If outside, give location) Lockwood	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Max Middle Heilbrunn Last Heilbrunn			4. DATE OF DEATH Month Aug Day 26 Year 1959		
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH April 11 1897	9. AGE (last birthday) 62	IF UNDER 1 YEAR Months 4 Days 15
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician		10b. KIND OF BUSINESS OR INDUSTRY Medical	11. BIRTHPLACE (City and state or country) Germany		12. CITIZEN OF WHAT COUNTRY usa
13a. FATHER'S NAME Abraham Heilbrunn		13b. MOTHER'S MAIDEN NAME Betty Sichel		14. NAME OF HUSBAND OR WIFE Ilse Heilbrunn	
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. no		17. INFORMANT Address Ilse Heilbrunn Lockwood 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) Amiotrophic Lateral Sclerosis		INTERVAL BETWEEN ONSET AND DEATH year +
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. 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)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	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. Month _____ Day _____ Year _____	20d. INJURY OCCURRED WHILE AT WORK <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 **7-20-59** to **8-26-59** and last saw him alive on **8-26-59**
Death occurred at **8:15P** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Lee A Mc Neely MD	(Degree or title)	22b. ADDRESS Greenfield Mo	22c. DATE SIGNED 8-28-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Aug 28 1959	23c. NAME OF CEMETERY OR CREMATORY Lockwood	23d. LOCATION (City, town, or county) Lockwood Mo	(State)
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24. FUNERAL DIRECTOR Allison Funeral Home Greenfield Mo.	25. DATE RECD. BY LOCAL REG. 8/31/1959	26. REGISTRAR'S SIGNATURE J. C. Canada
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(Licensed Embalmer, Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

NOV 9 1959

SEP 17 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 W.R. Allison

Licensed Embalmer No. 440

P. O. Address Greenville

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.