

FEDERAL BUREAU OF INVESTIGATION
 FBI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-002366

FILED VS FEB 1 1960 383

Registration District No. _____ Primary Registration District No. 5655 Registrar's No. _____

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Lawrence</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Davies</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Mt. Vernon</u>			Length of stay in 1b <u>8 days</u>		c. CITY, OR TOWN <u>Winston</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in Hospital, give location) HOSPITAL OR INSTITUTION <u>Mo. State Sanatorium</u>				Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Robert</u> Last <u>Heldenbrand</u>				4. DATE OF DEATH Month <u>January</u> Day <u>29</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>9-19-91</u>	9. AGE (last birthday) <u>68</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Pumper Shell Oil Co.</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Shell Oil Co.</u>		11. BIRTHPLACE (City and state or country) <u>Nebraska</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>Adam A. Heldenbrand</u>			13b. MOTHER'S MAIDEN NAME <u>Roberta M. Allen</u>			14. NAME OF HUSBAND OR WIFE <u>Leota L. Heldenbrand</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>			16. SOCIAL SECURITY NO. <u>494-01-9902</u>		17. INFORMANT Address <u>San. records, Mo. State San., Mt. Vernon, Mo.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of right lung</u>							INTERVAL BETWEEN ONSET AND DEATH <u>?</u>
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		
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 <u>1-21-60</u> to <u>1-29-60</u> and last saw him alive on <u>1-29-60</u> Death occurred at <u>10:05 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Deceased or title) <u>George Hohler, M.D.</u>				22b. ADDRESS <u>Mt. Vernon, Missouri</u>		22c. DATE SIGNED <u>1-29-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>1-29-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Winston Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Winston Mo.</u>			
24. FUNERAL DIRECTOR <u>Virgie V Stroup</u>		ADDRESS <u>Winston Mo</u>		25. DATE RECD. BY LOCAL REG. <u>1-29-1960</u>	26. REGISTRAR'S SIGNATURE <u>W D Forsett</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DOCK I I NEW SAE

SEP 13 1960

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 ml, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed W D Farnett

Licensed Embalmer No. 220
P. O. Address mt verna

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