

**JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**60-004338**

**FILED VS FEB 15 1960**

Registration District No. **317** Primary Registration District No. **544 541** Registrar's No. **303** STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <b>ST LOUIS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO</b> b. COUNTY <b>ST. LOUIS</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>CLAYTON</b>		Length of stay in 1b <b>D.O.A</b>	c. CITY OR TOWN <b>2468 OAKLAND</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST LOUIS CO. HOSPITAL</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>SYCAMORE HILLS</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) <b>DAVID FRED HECK</b>	First Middle Last	4. DATE OF DEATH <b>1 28 29 1960</b>	Month Day Year
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5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>4-15-1896</b>	9. AGE (last birthday) <b>63</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BAKER</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>RETIRED</b>	11. BIRTHPLACE (City and state or country) <b>OBONG ILLINOIS</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>DR. DAVID FIRM HECK</b>	13b. MOTHER'S MAIDEN NAME <b>MARY SHEETS</b>	14. NAME OF HUSBAND OR WIFE <b>FRANCES HECK</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, and of what branch) (If yes, give war or dates of service) <b>WWI</b>	16. SOCIAL SECURITY NO. <b>NONE</b>	17. INFORMANT Address <b>FRANCES HECK 2468 OAKLAND</b>
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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) <b>Unknown Natural Causes</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____	INTERVAL BETWEEN ONSET AND DEATH
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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 type="checkbox"/> NO <input checked="" 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.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 \_\_\_\_\_ to \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_  
Death occurred at **3:30 A.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>John C. Murphy M.D. Asst. Health Commissioner</b>	22b. ADDRESS <b>801 S. Brentwood Clayton, Mo.</b>	22c. DATE SIGNED <b>2-4-60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>2-1-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>NATIONAL CEMETERY J.B.</b>	23d. LOCATION (City, town, or county) (State) <b>MO</b>
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24. FUNERAL DIRECTOR ADDRESS <b>EARL HILLEMANN 9769 OAKLAND</b>	25. DATE RECD. BY LOCAL REG. <b>1-29-60</b>	26. REGISTRAR'S SIGNATURE <b>John C. Murphy M.D.</b>
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BY AFFIDAVIT OF Funeral Director MEDICAL CERTIFICATION DOCUMENT

**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 Carl S. Williams

Licensed Embalmer No. 3501

P. O. Address Orland, Va.

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.