

MRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS APR 4 1960

60-012696

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's **2 3350**

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE Missouri b. COUNTY				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis,			Length of stay in 1b		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Missouri Baptist Hospital				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 2109 Salisbury		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Anna Heitz			4. DATE OF DEATH Month Day Year March 23-60					
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>		8. DATE OF BIRTH 1899	9. AGE (last birthday) 60	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Chicago Ill.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Not known			13b. MOTHER'S MAIDEN NAME Not known			14. NAME OF HUSBAND OR WIFE Charles Heitz		
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.		17. INFORMANT Box 104 Rt. 2 Eileen Puckett High Ridge 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) Renal failure							INTERVAL BETWEEN ONSET AND DEATH Several weeks	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Occlusion of renal arteries DUE TO (c) Embolism of aorta 454x							"	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Mitral valvulitis myocardial fibrosis							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	
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 March 12, 1960 to March 23, 1960 and last saw her alive on March 22, 1960 Death occurred at 3⁰⁰ A m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) Hawey Walker, Jr., M.D.				22b. ADDRESS 462 N. Taylor Ave. St. Louis 8, Mo.		22c. DATE SIGNED 3/23/60		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-25-60	23c. NAME OF CEMETERY OR CREMATORY Sun Set Hills		23d. LOCATION (City, town, or county) (State) Potosi, Mo.			
24. FUNERAL DIRECTOR Oman Jenkins Potosi, Mo.			25. DATE RECD. BY LOCAL REG. MAR 23 1960		26. REGISTRAR'S SIGNATURE Roan Smith, M.D. <i>mjr.</i>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS APR 4 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 _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

John N. Shipman

Licensed Embalmer No. 4881

P. O. Address

Bismarck,

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.