

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

60-026435

STATE FILE NUMBER

Registration District No. 118 Primary Registration District No. 4189 Registrar's No. 22

1. PLACE OF DEATH a. COUNTY <u>Gasconade</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Gasconade</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Rosebud</u>		Length of stay in lb <u>6 months</u>	c. CITY OR TOWN <u>Rosebud</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Residence</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Residence</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Frederick</u> Last <u>Heidbrink</u>			4. DATE OF DEATH Month <u>July</u> Day <u>9</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>1-7-1888</u>	9. AGE (last birthday) <u>72</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farming</u>	11. BIRTHPLACE (City and state or country) <u>Drake, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>Herman H. Heidbrink</u>		13b. MOTHER'S MAIDEN NAME <u>Amelia Niewald</u>		14. NAME OF HUSBAND OR WIFE <u>Dora Kreutzer Heidbrink</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>487-38-2338</u>	17. INFORMANT <u>Mrs. Dora Heidbrink Rosebud, 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>Coccyary Thrombosis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>6 1/2 wks</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Chronic Myocardial Degeneration</u>					<u>1 yr +</u>
DUE TO (c) <u>Arteriosclerosis</u>					<u>1 yr +</u>
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 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.)			
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> 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>5-21-60</u> to <u>7-9-60</u> and last saw ^{him} <u>him</u> alive on <u>7-9-60</u> Death occurred at <u>2:00 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Paula H. H. Winter, M.D.</u> (Degree or title)			22b. ADDRESS <u>Owensville, Mo.</u>		22c. DATE SIGNED <u>7-9-60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>7-11-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lutheran Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Rosebud, Mo.</u>	
24. FUNERAL DIRECTOR <u>Gottenstroeter F. Home</u> ADDRESS <u>Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>July 11, 1960</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Maurine Jappmeyer</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Malford H. Winter (Licensed Embalmer's Statement on Reverse Side)

JUL 20 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 me Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Melford H H 2k

Licensed Embalmer No. 38

P. O. Address OWENS

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.