

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-047187

FILED VS DEC 29 1960 310

3058

STATE FILE NUMBER

Registration District No. Primary Registration District No. Registrar's No. 258

DED

1. PLACE OF DEATH a. COUNTY <b>St. Charles</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>St. Charles</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Charles</b>		Length of stay in 1b	c. CITY OR TOWN <b>St. Charles</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>925 North Third St.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>925 No. Third St.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Magdelene</b> Middle <b>Johanna</b> Last <b>Heckmann</b>			4. DATE OF DEATH Month <b>Dec.</b> Day <b>20</b> Year <b>1960</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 12, 1882</b>	9. AGE (last birthday) <b>78</b>	IF UNDER 1 YEAR Months <b>9</b> Days <b>8</b>
IF UNDER 24 HR Hours <b>8</b> Min.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maid</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>	11. BIRTHPLACE (City and state or country) <b>St. Peters, Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13a. FATHER'S NAME <b>Frank A. Heckmann</b>		13b. MOTHER'S MAIDEN NAME <b>Elizabeth J. Pieper</b>		14. NAME OF HUSBAND OR WIFE <b>None</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Margaret Heckmann, St. Charles, Mo.</b>		
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>Gastric Hemorrhage</b> <b>unknown cause</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <b>6 hr</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Epithelioma of face</b>				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 _____ 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 <b>1954</b> to <b>1960</b> and last saw her <sup>her</sup> alive on <b>Dec 18, 1960</b> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>W.A. Poyles</b> (Degree or title) <b>MD</b>			22b. ADDRESS <b>St Charles, Mo</b>		22c. DATE SIGNED <b>Dec 21, 1960</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Dec. 22, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Peters Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Charles, Mo.</b>		
24. FUNERAL DIRECTOR <b>H. C. Dallmeyer &amp; Sons, St. Charles, Mo.</b>		ADDRESS	25. DATE RECD. BY LOCAL REG. <b>12/21/60</b>	26. REGISTRAR'S SIGNATURE <b>Marcella Wilson</b>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

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.