SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-015907
STATE FILE NUMBER

AMENDED ✓ Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1048

FILED APR 24 1961

DATE AMENDED | INSTEAD OF | SHOULD READ | ITEM NO. | BY AFFIDAVIT OF | DOCUMENT

1. PLACE OF DEATH
a. COUNTY: St. Louis
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Affton — Length of stay in 1b: 5 Years
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: 9013 Kickapoo Dr. — Inside Limits: Yes ✓ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo. b. COUNTY: St. Louis
c. CITY OR TOWN: Affton — Inside Limits: Yes ✓ No ☐
d. STREET ADDRESS (If outside, give location): 9013 Kickapoo Dr. — Reside on Farm: Yes ☐ No ✓

3. NAME OF DECEASED (Type or print): First: BERTON Middle: K. Last: HEIL
4. DATE OF DEATH: Month: Apr. Day: 15 Year: 1961
5. SEX: Male
6. COLOR OR RACE: White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 12-29-1905
9. AGE (last birthday): 55 — 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): Superintendent-Falstaff
10b. KIND OF BUSINESS OR INDUSTRY: Brewing Co.
11. BIRTHPLACE (City and state or country): St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Frederick J. Heil
13b. MOTHER'S MAIDEN NAME: Catherine J. Enright
14. NAME OF HUSBAND OR WIFE: Rose F. Heil
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): 1923-1927
17. INFORMANT: Rose F. Heil Address: 9013 Kickapoo Dr.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Amyotrophic Lateral Sclerosis — INTERVAL BETWEEN ONSET AND DEATH: 1½ yrs.
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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 Jan 26, 1954, to April 15, 1961 and last saw her/him alive on April 14, 1961
Death occurred at 8:00 A.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Raymond Martin, MD (Degree or title)
22b. ADDRESS: 5203 Chippewa St
22c. DATE SIGNED: 4-17-61

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: Apr. 18, 1961
23c. NAME OF CEMETERY OR CREMATORY: National Cemetery
23d. LOCATION (City, town, or county) (State): Jefferson Barracks, Mo.

24. FUNERAL DIRECTOR: Kriegshauser ADDRESS: 4228 S. Kingshighway Blvd.
25. DATE RECD. BY LOCAL REG.: 4-17-61
26. REGISTRAR'S SIGNATURE: John C. Murphy M.D.

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____, Student Embalmer No._____ working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. 4533

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.