

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-028861

STATE FILE NUMBER

Registration District No. 119 Primary Registration District No. 5993 Registrar's No. 93

AMENDED

FILED SEP 11 1961

1. PLACE OF DEATH a. COUNTY <u>Gasconade</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Gasconade</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Roark Twp</u>		Length of stay in 1b <u>14 days</u>	c. CITY OR TOWN <u>Hermann</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Greene Valley Nursing Home</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>200 W. Second St</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNA MARIE HECKMANN</u>			4. DATE OF DEATH Month Day Year <u>Aug 25 1961</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cau.</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12/23/1870</u>
9. AGE (last birthday) <u>90</u>		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) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Household</u>	11. BIRTHPLACE (City and state or country) <u>Hermann, Mo</u>
12. CITIZEN OF WHAT COUNTRY <u>US</u>		13a. FATHER'S NAME <u>Fritz Buddemeyer</u>	
13b. MOTHER'S MAIDEN NAME <u>Tina Kubitz</u>		14. NAME OF HUSBAND OR WIFE <u>Wm L. Heckmann</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>None</u>	17. INFORMANT Address <u>Mrs. Hazel Vogel Hermann, 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>Hypostatic pneumonia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Chronic myocardial failure</u>			<u>2 years</u>
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. <input type="checkbox"/> Yes <input checked="" 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 <u>5/28/57</u> , to <u>8/25/61</u> and last saw her alive on <u>8/25/61</u> Death occurred at <u>4:29 P. M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>H. A. Blumer, M.D.</u>		22b. ADDRESS <u>Hermann, Mo.</u>	22c. DATE SIGNED <u>8/26/61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8/26/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hermann Cemetery</u>	23d. LOCATION (City, town, or county) <u>Hermann Mo</u>
24. FUNERAL DIRECTOR ADDRESS <u>HERMAN BLUMER INC Hermann, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>8-27-61</u>	26. REGISTRAR'S SIGNATURE <u>Delma Uffelmann</u>	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

SEP 11 1961

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 ORVAL GRONER, Student Embalmer No. 641

working under my personal supervision.

Student Orval Groner
Signature of Student Embalmer

Signed August Groner

Licensed Embalmer No. 3160

P. O. Address Hermann

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.