

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-033921

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Registration District No. 210  
 FILED SEP 27 1961

Primary Registration District No. 3058

Registrar's No. 235

STATE FILE NUMBER

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT  
 MEDICAL CERTIFICATION  
 BY AFFIDAVIT OF

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> b. COUNTY <b>St. Charles</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Charles</b>		c. CITY OR TOWN <b>St. Charles</b>	
Length of stay in 1b <b>Life</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>St. Joseph Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>412 Boone Ave.</b>	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Josephine M. Heckmann</b>			4. DATE OF DEATH Month Day Year <b>Sept. 18, 1961</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>Aug. 16, 1888</b>
9. AGE (last birthday) <b>73</b>		IF UNDER 1 YEAR Months <b>1</b> Days <b>2</b>	IF UNDER 24 HR Hours <b>2</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (City and state or country) <b>St. Charles, Mo.</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13a. FATHER'S NAME <b>George L. Heckmann</b>	
13b. MOTHER'S MAIDEN NAME <b>Louise Thoerner</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>Walter 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>Broncho pneumonia</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>
Conditions, if any, which gave rise to above cause (a), starting 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. <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>Sept 8, 1961</b> to <b>Sept 18, 1961</b> and last saw her alive on <b>Sept 17, 1961</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.H. Roggemans MD</b> (Degree or title)		22b. ADDRESS <b>St Charles Mo</b>	22c. DATE SIGNED <b>9-22-61</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Sept. 21, 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Peter 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>		25. DATE RECD. BY LOCAL REG. <b>Sept 26-61</b>	26. REGISTRAR'S SIGNATURE <b>Marella Wilson</b>

**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 Frank R. Amalenc

Licensed Embalmer No. 48326

P. O. Address St Charles

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.