

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-027754

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 384 Primary Registration District No. 3099 Registrar's No. 151

<p>FILED <u>JUL 31 1962</u></p>		<p>1. PLACE OF DEATH a. COUNTY <u>Linn</u></p>		<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Linn</u></p>		
<p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Brookfield</u></p>		<p>Length of stay in 1b <u>20 yrs</u></p>		<p>c. CITY OR TOWN <u>Brookfield</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>		
<p>c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Brookfield Nursing Home</u></p>			<p>Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>		<p>d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>	
<p>3. NAME OF DECEASED (Type or print) First Middle Last <u>Oscar H. Heckman</u></p>			<p>4. DATE OF DEATH Month Day Year <u>July 27, 1962</u></p>			
<p>5. SEX <u>M</u></p>	<p>6. COLOR OR RACE <u>W</u></p>	<p>7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <u>2-20-1871</u></p>	<p>9. AGE (last birthday) <u>91</u></p>	
<p>IF UNDER 1 YEAR Months Days</p>		<p>IF UNDER 24 HR Hours Min.</p>				
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer - ret.</u></p>		<p>10b. KIND OF BUSINESS OR INDUSTRY <u>Own farm</u></p>		<p>11. BIRTHPLACE (City and state or country) <u>Dixon, Illinois</u></p>		
<p>12. CITIZEN OF WHAT COUNTRY <u>USA</u></p>		<p>13a. FATHER'S NAME <u>Levi Heckman</u></p>		<p>13b. MOTHER'S MAIDEN NAME <u>Catherine Mossholder</u></p>		
<p>14. NAME OF HUSBAND OR WIFE <u>Alice Potter Heckman</u></p>		<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u></p>				
<p>16. SOCIAL SECURITY NO.</p>		<p>17. INFORMANT Address <u>M. E. Heckman, Brookfield, Mo.</u></p>				
<p>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>CARCINOMA PROSTATE</u></p>					<p>INTERVAL BETWEEN ONSET AND DEATH <u>APPROX 24RS</u></p>	
<p>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____</p>						
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)</p>				<p>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</p>		
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	<p>20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/></p>	<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)</p>				
<p>20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year</p>						
<p>20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p>	<p>20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	<p>20f. CITY, TOWN, OR LOCATION</p>	<p>COUNTY</p>	<p>STATE</p>		
<p>21. I attended the deceased from <u>5-15-62</u> to <u>7-27-62</u> and last saw ^{her}him alive on <u>7-26-62</u> Death occurred at <u>8:30 p</u> m on the date stated above, and to the best of my knowledge, from the causes stated.</p>						
<p>22a. SIGNATURE (Degree or title) <u>H. H. Potter DO.</u></p>			<p>22b. ADDRESS <u>MASONIC BLDG. BROOKFIELD MO.</u></p>		<p>22c. DATE SIGNED <u>7-28-62</u></p>	
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u></p>	<p>23b. DATE <u>7-29-1962</u></p>	<p>23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u></p>		<p>23d. LOCATION (City, town, or county) (State) <u>Brookfield, Mo.</u></p>		
<p>24. FUNERAL DIRECTOR ADDRESS <u>Wright Funeral Home, Brookfield, Mo.</u></p>			<p>25. DATE RECD. BY LOCAL REG. <u>7-28-62</u></p>	<p>26. REGISTRAR'S SIGNATURE <u>Anna Watson</u></p>		

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DATE AMENDED
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF
SHOULD READ
ITEM NO.

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

USE BLACK INK
OR
TYPEWRITER RIBBON

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 Harold B. Wright

Licensed Embalmer No. 3718

P. O. Address Brookfield, Mo.

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.