

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-034163

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 77

Primary Registration District No. 3016

Registrar's No. 354

FILED SEP 17 1962

VS 300  
Rev. 4/59

0269  
2/6/81

3

4 0

5 1

6

7 0

8 1

95410

10

11

123-0

13 1-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>COLE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Moniteau</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>JEFFERSON City</u>		Length of stay in lb <u>2 days</u>	c. CITY OR TOWN <u>California</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Memorial Comm. Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>IN CITY</u>
3. NAME OF DECEASED (Type or print) First <u>Theodore</u> Middle <u>Erwin</u> Last <u>Heysse</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>12</u> Year <u>1962</u>	

5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8-30-1880</u>	9. AGE (last birthday) <u>82</u>	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) <u>Retired</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>GEN. MERCHANDISE</u>	11. BIRTHPLACE (City and state or country) <u>JAMESTOWN Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>
---	--	--	--

13a. FATHER'S NAME <u>F.W.T. HEYSSEL</u>	13b. MOTHER'S MAIDEN NAME <u>CAROLINE SCHULTZ</u>	14. NAME OF HUSBAND OR WIFE <u>GERTRUDE HEYSSEL</u>
---	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) <u>NO</u>	16. SOCIAL SECURITY NO. <u>[REDACTED]</u>	17. INFORMANT <u>MRS. GERTRUDE HEYSSEL, CALIFORNIA, MO.</u>
--	---	--

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Anemic-anoxia with shock,</u>		<u>2 days</u>
DUPLICATE TO (b) <u>hemorrhage from duodenal ulcer</u>		<u>2 weeks</u>
DUPLICATE TO (c) <u>Myocardial infarction, healed</u>		
DUPLICATE TO (d) <u>arteriosclerosis, generalized</u>		

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 checked="" type="checkbox"/> NO <input 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 7-25-1956 to 9-12-1962 and last saw him alive on 9-12-1962  
Death occurred 4:45 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Richard B. Clark, MD</u>	22b. ADDRESS <u>Jefferson City, MO</u>	22c. DATE SIGNED <u>9-12-62</u>
---	---	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>9-14-1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MASONIC CEMETERY</u>	23d. LOCATION (City, town, or county) <u>CALIFORNIA, MO.</u>
--	-------------------------------	---	---

24. FUNERAL DIRECTOR <u>Hugh E. Williams, California, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>14 September 1962</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>
--	--	---

APR 18 1963

**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 Russell C. Maag

Licensed Embalmer No. 4884

P. O. Address California, 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.