

FILED OCT 21 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER **36510**

Registration District No. **174** Primary Registration District No. **3035** Registrar's No. **98**

1. PLACE OF DEATH a. COUNTY <b>Lafayette</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Lafayette</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Lexington</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Lexington</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>Memorial Hospital</b> Length of stay in lb <b>5 days</b>		d. STREET ADDRESS (If outside, give location) <b>23rd and Jefferson</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>DAWSON</b> First <b>DAVID</b> Middle <b>HEATHMAN</b> Last		4. DATE OF DEATH <b>September 11 1957</b> Month <b>September</b> Day <b>11</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>August 12, 1905</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Lake City Arsenal</b>		9b. AGE (In years last birthday) <b>52</b>	9c. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>5</b> Days <b>2</b> Hours <b>2</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Lake City Arsenal</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>ammunition</b>	10c. BIRTHPLACE (City and state or country) <b>Lexington, Missouri</b>
11. BIRTHPLACE (City and state or country) <b>Lexington, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>David O. Heathman</b>		14. MOTHER'S MAIDEN NAME <b>Clara Dawson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>5870</b>	
17. INFORMANT <b>Dawson H. Heathman, Lexington, Mo</b>		Address	
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>Acute pancreatitis</b> 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) _____			INTERVAL BETWEEN ONSET AND DEATH <b>5 da.</b>
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 _____ Month _____ Day _____ a. m. _____ p. m. _____			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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>1923</b> to <b>9/10/57</b> and last saw <b>her</b> him alive on <b>9/10/57</b> Death occurred at <b>1:15 AM</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Ben H. Beasher M.D.</b> (Degree or title)		22b. ADDRESS	22c. DATE SIGNED <b>10-6-57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
<b>Burial</b>	<b>Sept. 12, 1957</b>	<b>Machpelah</b>	<b>Lexington, Missouri.</b>
24. FUNERAL DIRECTOR <b>Forest T. Tempel Lexington, Missouri</b>		25. DATE RECD. BY LOCAL REG. <b>10-8-57</b>	26. REGISTRAR'S SIGNATURE <b>Minna E. Eastbrook</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

MAR 23 1959

**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. 298

P. O. Address *Stoughton, Mass.*

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.