

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

0034930

STATE FILE NUMBER

Registration District No. 137 Primary Registration District No. 3023 Registrar's No. \_\_\_\_\_

DO NOT WRITE ON THIS STUB

AMENDED

<b>FILED OCT 5 1964</b>	
<p><b>1. PLACE OF DEATH</b></p> <p>a. COUNTY <u>Henry</u></p> <p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clinton</u> Length of stay in 1b <u>5 days</u></p> <p>c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Clinton General</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p><b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE <u>Missouri</u> b. COUNTY <u>Henry</u></p> <p>c. CITY OR TOWN <u>Clinton</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p> <p>d. STREET ADDRESS (If outside, give location) <u>RR # 5</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>
<p><b>3. NAME OF DECEASED</b> (Type or print)</p> <p>First <u>Anna</u> Middle <u>M</u> Last <u>Heiman</u></p>	<p><b>4. DATE OF DEATH</b></p> <p>Month <u>Sept</u> Day <u>25</u> Year <u>1964</u></p>
<p><b>5. SEX</b> <u>Female</u></p> <p><b>6. COLOR OR RACE</b> <u>White</u></p> <p><b>7. Married</b> <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/></p>	<p><b>8. DATE OF BIRTH</b> <u>27 July 1892</u></p> <p><b>9. AGE</b> (last birthday) <u>92</u></p> <p><b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u></p> <p><b>10b. KIND OF BUSINESS OR INDUSTRY</b></p>
<p><b>11. BIRTHPLACE</b> (City and state or country) <u>Altamont Ill</u></p> <p><b>12. CITIZEN OF WHAT COUNTRY</b> <u>USA</u></p>	<p><b>13a. FATHER'S NAME</b> <u>John Swaters</u></p> <p><b>13b. MOTHER'S MAIDEN NAME</b> <u>Elizabeth Wehcamp</u></p> <p><b>14. NAME OF HUSBAND OR WIFE</b> <u>Fred Heiman</u></p>
<p><b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u></p>	<p><b>16. SOCIAL SECURITY NO.</b> _____</p> <p><b>17. INFORMANT</b> <u>Mrs Lovetta Hogan</u> Address <u>Clinton Mo</u></p>
<p><b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:</p> <p style="text-align: center;">IMMEDIATE CAUSE (a) <u>Uremia</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u></p> <p style="text-align: center;">Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Nephrosclerosis</u> <u>one yr.</u></p> <p style="text-align: center;">DUE TO (c) <u>Senesclized arterio-sclerosis</u> <u>4 yrs.</u></p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>None</u></p> <p>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</p>	
<p><b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> <p><b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/></p> <p><b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.) _____</p>	<p><b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____</p> <p><b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p> <p><b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____</p> <p><b>20f. CITY, TOWN, OR LOCATION</b> _____ <b>COUNTY</b> _____ <b>STATE</b> _____</p>
<p><b>21. I attended the deceased from</b> <u>2/7/47</u> to <u>9/25/64</u> and last saw her alive on <u>9/23/64</u></p> <p>Death occurred at <u>5:53 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.</p>	
<p><b>22a. SIGNATURE</b> (Degree or title) <u>S.B. Hughes, M.D.</u></p>	<p><b>22b. ADDRESS</b> <u>Clinton, Mo</u></p> <p><b>22c. DATE SIGNED</b> <u>9/30/64</u></p>
<p><b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u></p> <p><b>23b. DATE</b> <u>Sept 28-1964</u></p> <p><b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>St Mary's cemetery</u></p> <p><b>23d. LOCATION</b> (City, town, or county) <u>Montrose Mo</u> (State)</p>	<p><b>24. FUNERAL DIRECTOR</b> <u>Sickman-Dunning FH @Clinton Mo</u> ADDRESS _____</p> <p><b>25. DATE RECD. BY LOCAL REG.</b> <u>Oct. 2, 1964</u></p> <p><b>26. REGISTRAR'S SIGNATURE</b> <u>Waldred Bigman</u></p>

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

ITEM NO.

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

284250

10-1-11

Permit Obtained 9-28-64  
MB

**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 R. J. Dunning

Licensed Embalmer No. 4710

P. O. Address Clinton 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.