

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

0018311

Registration District No. 64 53 Primary Registration District No. 3010 Registrar's No. 267 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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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

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Cape Girardeau</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cape Girardeau</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Cape Girardeau</u> | | c. CITY OR TOWN <u>Cape Girardeau</u> | |
| Length of stay in 1b <u>16 Yrs</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Southeast Mo Hospital</u> | | d. STREET ADDRESS (If outside, give location) <u>1813 No West End Blvd.</u> | |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED First Middle Last <u>Louise Heise</u> | | | 4. DATE OF DEATH Month Day Year <u>June 2, 1964</u> |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>2/1/1883</u> |
| 9. AGE (last birthday) <u>81</u> | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HR |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> | 11. BIRTHPLACE (City and state or country) <u>Near Egypt Mills</u> |
| 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | | 13a. FATHER'S NAME <u>John Baker</u> | |
| 13b. MOTHER'S MAIDEN NAME <u>Unknown</u> | | 14. NAME OF HUSBAND OR WIFE <u>Albert Heise</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | |
| 17. INFORMANT (Name) <u>Mrs Leo Deimund, Jackson, Mo.</u> | | Address <u>Route # 4</u> | |
| 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>Respiratory failure</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> |
| DUE TO (b) <u>Cerebrovascular accident (hemorrhage)</u> | | | <u>48 hrs</u> |
| DUE TO (c) <u>Essential hypertension</u> | | | <u>7 yrs.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Hypertensive cardio vascular disease</u> | | | 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 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 <u>9/25/59</u> to <u>6/2/64</u> and last saw <u>live</u> on <u>6/2/64</u> Death occurred at <u>12:23</u> P.m. on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) <u>Joe Cochran MD</u> | | 22b. ADDRESS <u>24 North Sprigg St. Cape Girardeau, Missouri</u> | 22c. DATE SIGNED <u>6/3/64</u> |
| 23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>June 4, 1964</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Egypt Mills Lutheran</u> | 23d. LOCATION (City, town, or county) (State) <u>Egypt Mills, Missouri</u> |
| 24. FUNERAL DIRECTOR <u>C.J. Lorberg, Cape Girardeau, Mo.</u> | 25. DATE RECD. BY LOCAL REG. <u>6-3-1964</u> | 26. REGISTRAR'S SIGNATURE <u>Gene Kasten</u> | |

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 *A. J. Norberg*

Licensed Embalmer No. 3810

P. O. Address *Cape Girardeau, 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.

This certificate taken to Doctor: June 3, 1964

This certificate received from Doctor: June 3, 1964