

P. S. No. 2
OM-8-43
ev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **40999**

FILED JAN 12 1945
82

Primary Registration District No. **3017**

Registrar's No. **173**

1. PLACE OF DEATH:

(a) County **Cooper**

(b) City or town **Boonville**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Joseph Hospital.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **1 Day**
(Specify whether years, months or days)

In this community: **All of life.**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Cooper 27**

(c) City or town **Boonville**
(If outside city or town limits, write "RURAL")

(d) Street No. **1026 Third St.**
(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Mrs. Annie Heisler.**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec.** day **8**
year **1944** hour **8** minute **30 a.** M.

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife **Lawrence Heisler.** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **February 11 1875**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Dec 7, 1944**, to **Dec 8, 1944**, that I last saw her alive on **Dec 7, 1944**, and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	69	9	37	hr. _____ min. _____

Immediate cause of death **Cerebral Hemorrhage** Duration **24 hrs.**

9. Birthplace **Cooper County, Missouri.**
(City, town, or county) (State or foreign country)

Due to **Hypertension**

10. Usual occupation **Housewife.**

Due to **Arterio Sclerosis**

11. Industry or business **At home.**

Other conditions **Chronic Valvular Heart Disease**
(Include pregnancy within 3 months of death)

12. Name **Sebastian Strickfadden.**

Major findings: Of operations _____

13. Birthplace **Germany.**
(City, town, or county) (State or foreign country)

Of autopsy **92d**

14. Maiden name **Elizabeth Winegardner**

15. Birthplace **Unknown.**
(City, town, or county) (State or foreign country)

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant **Mrs. Lowell Hunter.**

(b) Address **Boonville, Mo.**

17. (a) **Burial** (b) Date thereof **Dec. 11/1944**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Cedron, Mo.**

18. (a) Signature of funeral director **Woodman & Hollen**

(b) Address **Boonville, Mo.**

19. (a) **Dec-9-44** (b) **Dr Ghas Swap.**
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:

(c) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature **M. H. Ziegler** (M. D. or other) **M.D.**

Address **Boonville Mo.** Date signed **12/8/44**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

27
1
2

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 1-9-45

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed *J. W. Goodman*

Licensed Embalmer No. *1178*

P. O. Address *Boonville, 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 this body is not embalmed, fact should be so stated above.