24 1929

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

24224

1. PLACE OF DEATH

County: Dent — Registration District No.: 271 — File No.:

Township: Watkins — Primary Registration District No.: 5378 — Registered No.: 15

City: Salem (No. ..... St. ..... Ward)

2. FULL NAME John Jefferson Headrick

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Lillie C. Inman

6. DATE OF BIRTH (MONTH, DAY AND YEAR): July 22 1850

7. AGE: 78 YEARS — MONTHS: 11 — DAYS: 10 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: .....

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): North Carolina

PARENTS

10. NAME OF FATHER: Casper Headrick
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Dont/know
12. MAIDEN NAME OF MOTHER: Betty Frank
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Dont/know

14. INFORMANT: Cleve Headrick
(Address): Salem Mo.

15. FILED: JUL 2 1929 — F W Carney, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): July 1 1929

17. I HEREBY CERTIFY, That I attended deceased from June 4, 1929, to July 1, 1929, that I last saw him alive on June 20, 1929, and that death occurred, on the date stated above, at 8:15 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Senile Debility
Myocarditis
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY): 908
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? no DATE OF .....
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? none

(Signed) W J Dickerson, M. D
, 19 (Address) Renox Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Round Pond — DATE OF BURIAL: 7/2 1929

20. UNDERTAKER: Carl Spencer — ADDRESS: Salem Mo.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

[illegible]

[illegible]

[illegible]