

15:49 APR 19 1939

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

11576  
Do not use this space.

1. PLACE OF DEATH 2

(a) County Milleer Registration District No. 561

(b) Township Franklin Primary Registration District No. 5-75-6 Registered No. 2:204

(c) City Eldon (d) Street No. \_\_\_\_\_ St.

(e) Length of residence in city or town where death occurred \_\_\_\_\_ yrs. mos. ds. (f) How long in U. S., if of foreign birth? \_\_\_\_\_ yrs. mos. ds.

2. PRINT FULL NAME Isaac Thomas Hedrick

(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Julia Hedrick

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb. 18 1856

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
	<u>83</u>	<u>0</u>	<u>26</u>	

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. \_\_\_\_\_

9. Industry or business in which work was done, as saw mill, bank, etc. Farmer

10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri 0

FATHER 13. NAME Abraham Hedrick 9

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown 9

MOTHER 15. MAIDEN NAME Abbie Hall

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT (ADDRESS) Phillip Hess  
Eldon, Missouri

18. BURIAL, CREMATION, OR REMOVAL PLACE Union DATE 3-16-1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Phillips Funeral Home

20. FILED 3-16-1939 Belle Haynes  
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-14-1939 1939

22. I HEREBY CERTIFY, That I attended deceased from Mar. 13, 1939, to Mar. 14, 1939

I last saw him alive on Mar. 13, 1939. Death is said to have occurred on the date stated above, at 6:30 P. M.

The principal cause of death and related causes of importance were as follows:  
Pneumonia

Date of onset 3/13/39

Other contributory causes of importance:  
Senility

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 1939  
Where did injury occur? \_\_\_\_\_  
(Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place. \_\_\_\_\_

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased?  
If so, specify \_\_\_\_\_  
(Signed) A. F. Burkholder M.D.  
\_\_\_\_\_ (Address) \_\_\_\_\_

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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RECEIVED

Miller County Health Dep't.

County File Number 39-36

Date Filed 4-12-39

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, .....

Louis D. Phillips, or by .....

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

Signed

*Louis D. Phillips*

Licensed Embalmer No. 3663

P. O. Address .....

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, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

115-76  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Miller Registration District No. 261  
 (b) Township Franklin Primary Registration District No. 0756 Registered No. ....  
 (c) City ..... (d) Street No. .... St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Isaac Thomas Hedeen  
 (a) Residence, No. .... St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) wid

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<u>83</u>	<u>0</u>	<u>26</u>	

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
 9. Industry or business in which work was done, as saw mill, bank, etc.  
 10. Date deceased last worked at this occupation (month and year)  
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER 13. NAME  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)  
 18. BURIAL, CREMATION, OR REMOVAL PLACE DATE 19  
 19. FUNERAL DIRECTOR (ADDRESS)  
 20. FILED 19

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3 - 14 1939

22. I HEREBY CERTIFY, That I attended deceased from 19... to 19...  
 I last saw him alive on 19... Death is said to have occurred on the date stated above, at... m.  
 The principal cause of death and related causes of importance were as follows:  
Pneumonia  
Bronchial  
 Other contributory causes of importance:  
Chilidipinemat  
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Name of operation ..... Date of .....  
 What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? ..... Date of injury ..... 19...  
 Where did injury occur? ..... (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....  
 Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....  
 If so, specify  
 (Signed) A. J. Berkesteiner M. D.  
 (Address) Edon, Mo

SUPPLEMENTARY  
 Requested by family informant

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S STATEMENT OF CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

Local Registrar.

MAY - 7 1939