

Registration District No. **318**

Primary Registration District No. **2001**

Registrar's No. **849**

**FILED NOV 12 1940**

1. PLACE OF DEATH:

(a) County **GREENE** Springfield  
(b) City or town  
(c) Name of hospital or institution:  
**1171 W. Mt Vernon St**  
(d) Length of stay: In hospital or institution **20**  
In this community **20** years, months or days

3. (a) PRINT FULL NAME **ANNA HEADY.**

8. (b) If veteran, name war **No.** 3. (c) Social Security No. **None**

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

6. (b) Name of husband or wife **D.E. Heady** 6. (c) Age of husband or wife if alive **66**

7. Birth date of deceased (Month) **June** (Day) **28** (Year) **1875**

8. AGE: Years **65** Months **3** Days **7** If less than one day hr. min.

9. Birthplace **Dallas Co. MO.**

10. Usual occupation **House wife**

11. Industry or business **House Work**

12. Name **James K. Polk Redman**

13. Birthplace **Uniontown Mo.**

14. Maiden name **Margaret Williams**

15. Birthplace **Uniontown Mo.**

16. (a) Informant **Elsie Heady**

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

17. (a) **Burial** (b) Date thereof **Oct 17 1940**

(c) Place: burial or cremation **Maple Park cemetery**

18. (a) Signature of funeral director **W. Springer**

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

19. (a) **10-17-40** (b) **W.E. Handley MD** (c) **W.E.**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Greene**  
(c) City or town **Springfield**  
(d) Street No. **1171 W. Mt Vernon**  
(e) If foreign born, how long in U. S. A.?

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct** day **15th** year **1940** hour **6** minute **45 P. M.**

21. I hereby certify that I attended the deceased from **October 12, 1940** to **October 15, 1940**  
that I last saw h. e. r. alive on **October 15, 1940**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Left Cerebral Occlusion** Duration **4 days**

Due to **Hypertension & generalized arteriosclerosis, 3 yrs.**

Other conditions **Multiple R. Cerebral occlusions - terminal pseudo**

Major findings **ultra poly.** Of operations **none** Of autopsy **none**

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

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

(a) Accident, suicide, or homicide (specify)  
(b) Date of occurrence  
(c) Where did injury occur?  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
(e) Means of injury

23. Signature **Rowland B. Hall** (M. D. or other) Address **500 Holland Bldg** Date signed **10/16/40**

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

**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.....

.....  
working under my personal supervision.

Signed

*William J. Hood*

....., Registered Apprentice No.....

Licensed Embalmer No.....

*4271*

P. O. Address

*Spring Hill*

**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.

X