

FILED MAR 3 1942  
Registration District No. \_\_\_\_\_

Primary Registration District No. **4467**

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0  
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH

(a) County **St. Francois**  
(b) City or town **Wasson**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether years, months or days)  
In this community \_\_\_\_\_

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Iron**  
(c) City or town **Bixby**  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **MARY J. HEDRICK**

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

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

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased **Aug 8 1869**  
(Month) (Day) (Year)

8. AGE: Years **72** Months **5** Days **17** If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace **Bixby Mo.**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Home work at home**

11. Industry or business **C.M. Day**

12. Name **Unknown** 13. Birthplace **Unknown**  
(City, town, or county) (State or foreign country)

14. Maiden name **Elizabeth Chandler** 15. Birthplace **Unknown**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Ike Hronick**  
(b) Address **Wasson**

17. (a) **Burial** (b) Date thereof **July 16 1942**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Bixby Mo.**

18. (a) Signature of funeral director **Wasson Mo.**  
(b) Address **Wasson Mo.**

19. (a) **July 26 42** (b) **F. W. Gale**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **25** day **July**  
year **1942** hour **9** minute **20 AM**

21. I hereby certify that I attended the deceased from **July 22** to **July 25** 19**42**  
that I last saw him **alive** on **July 25** 19**42**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic Myocarditis**  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)  
Major findings: Of operations **938**  
Of autopsy \_\_\_\_\_

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? \_\_\_\_\_ (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 **0**

23. Signature **F. W. Gale** (M. D. or other)  
Address **Wasson Mo.** Date signed **7/26/42**

ED

District Health Officer No. 4

District File Number 242-192

Date Filed 2-11-42

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**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.....

Licensed Embalmer No.....

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, fact should be so stated above.**