

S. No. 2
M-5-43
v. 5-17-39
I X36871

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
1003

State File No. **10960**
Registrar's No. **2319**

FILED APR 14 1947
Registration District No. **318**

Primary Registration District No. _____

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

1. PLACE OF DEATH:
(a) County **St. Louis, Missouri**
(b) City or town **St. Louis, Missouri**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Saint Louis Maternity**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **St. Louis**
(c) City or town **St. Louis Wellston**
(If outside city or town limits, write "RURAL")
(d) Street No. **1535 Engelholm**
(If rural, give location) **NR**
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **INFANT HEDRICK**
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

4. Sex **MALE**
5. Color or race **WHITE**
6. (a) Single, widowed, married, divorced **0**
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **March 20, 1947**
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____
If less than one day **23 hr. 40 min.**

9. Birthplace **St. Louis, Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER {
12. Name **Edgar Roland Hedrick**
13. Birthplace **St. Louis County, Mo**
(City, town, or county) (State or foreign country)
14. Maiden name **Eunice A. Schoenfeld**
15. Birthplace **St. Louis Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **Saint Louis Maternity**

(b) Address **630 S. Kingshighway**

17. (a) **Burial** (b) Date thereof **MAR 28 1947**
(Burial, cremation, or removal) (City or town) (County) (State) (Day) (Year)
(c) Place: burial or cremation **Anatomical Board**

18. (a) Signature of funeral director **Anatomical Board W. Ricketts**
(b) Address **3500 Rutledge**

19. (a) **0947 28 1947** (b) **J. F. Brebeck**
(Date received local Registrar's) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **MARCH** day **21**
year **1947** hour **8:30** minute _____ M.
21. I hereby certify that I attended the deceased from **Mar 20**
1947 to **Mar 21**
that I last saw him alive on **Mar 21**
and that death occurred on the date and hour stated above.

Immediate cause of death **Intracranial hemorrhage**
Atelectasis
Duration **22 hrs**
22 hrs

Due to _____
Due to **Hed**
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: _____
Of operations: _____
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 _____

23. Signature **John B. O'Neil** (M. D. or other) **MD**
Address **1222 Mummenheim** Date signed **3/25/47**

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.