

S. No. 2
M-5-43
5-17-39
I X3667

FILED APR 17 1947

Registration District No. 08

Primary Registration District No. 3018

Registrar's No. 31

3

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

1. PLACE OF DEATH:

(a) County DENT

(b) City or town SALEM
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
NONE
(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 DENT 33

(c) City or town SALEM 1
(If outside city or town limits, write "RURAL") 1

(d) Street No. _____ (If rural, give location) 0

(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME ISAAC 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 MARRIED

6. (b) Name of husband or wife ROSA HEDRICK 6. (c) Age of husband or wife if alive 57 years

7. Birth date of deceased FEB 3 1878
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

69 1 27 hr. min.

9. Birthplace DENT COUNTY MISSOURI
(City, town, or county) (State or foreign country)

10. Usual occupation BLIND PENSIONER

11. Industry or business _____

MOTHER FATHER

12. Name ABRAHAM HEDRICK 0

13. Birthplace DENT COUNTY MISSOURI
(City, town, or county) (State or foreign country)

14. Maiden name NO RECORD

15. Birthplace NO RECORD 9
(City, town, or county) (State or foreign country)

16. (a) Informant Rosa Hedrick 1
(b) Address SALEM, MISSOURI

17. (a) BURIAL (b) Date thereof 4-1-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CEDAR GROVE CEM.

18. (a) Signature of funeral director Carl A. Spencer

(b) Address SALEM, MISSOURI

19. (a) 3-31-47 (b) m m Hart, M.D. H. H. H.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MARCH day 30
year 1947 hour 2:55 minute P. M.

21. I hereby certify that I attended the deceased from 6-15-75, 1945 to 6-18-45, 1945;
that I last saw hm alive on 6-18-45, 1945;
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration seconds

Due to hypertension year

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations CS

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) (a) Means of injury _____

23. Signature M. M. Hart (M.D. or other) M.D.
Address Salem Mo Date signed 3-31-47

83

RECEIVED

District Health Officer No. 8,

District File Number 447207

Date Filed 4-15-47

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, only.....

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

Signed Wm. W. McDonald.....

Licensed Embalmer No. 3806.....

P. O. Address Salem, Mo......

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.