

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

24430

State File No.

FILED JUL 27 1953

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 683

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Stone</u>	
b. CITY OR TOWN <u>Springfield</u>		c. CITY OR TOWN <u>Reeds Spring</u>	
c. LENGTH OF STAY (in this place) <u>1 day</u>		1040 1	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Baptist Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>no street address</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>JAMES</u>	b. (Middle) <u>WESLEY</u>	c. (Last) <u>HEDRICK</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>July 24, 1953</u>
-------------------------------------	-------------------------	---------------------------	--------------------------	--

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>October 7, 1887</u>	9. AGE (In years last birthday) <u>65</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 2 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Stone Co., Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>

13a. FATHER'S NAME <u>Sigle Hedrick</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Baker</u>	14. NAME OF HUSBAND OR WIFE <u>---</u>
---	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Deward Hedrick</u>	ADDRESS <u>Reeds Spring, Missouri</u>
--	-------------------------------------	---	---------------------------------------

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Infarction of Left and Right</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>(partial) Cerebral Hemispheres</u> DUE TO (c) <u>Embolism</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Pulmonary - Kidney and Splenic Infarction</u>		INTERVAL BETWEEN ONSET AND DEATH
---	--	--	--	----------------------------------

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>None</u>	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
------------------------	--	--

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>331X</u>
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6:00 AM July 23, 1953, to 24 July, 1953, that I last saw the deceased alive on 24 July, 1953, and that death occurred at 7:10 P. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Stanley A. Peterson, M.D.</u>	23b. ADDRESS <u>Springfield, Mo.</u>	23c. DATE SIGNED <u>25 July 53</u>
---	--------------------------------------	------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>July 25, 1953</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Yocum Pond Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Reeds Spring, Mo.</u>
--	--------------------------------	---	--

DATE REC'D BY LOCAL REG. <u>7-25-53</u>	REGISTRAR'S SIGNATURE <u>Earl Williams</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Alma Schmezer</u>	ADDRESS <u>Springfield, Mo.</u>
---	--	---	---------------------------------

OCT 30 1935

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 _____

Student Embalmer No. _____

~~working under my personal supervision.~~

Student
Student Embalmer

Signed Carl J. Glenn

Licensed Embalmer No. 4707

P. O. Address Springfield

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.