

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-022370

STATE FILE NUMBER

FILED JUN 30 1958

Registration District No. 169 Primary Registration District No. 4258 Registrar's No. 30

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| 1. PLACE OF DEATH a. COUNTY <u>KNOX</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>KNOX</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>EDINA</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN <u>HURDLAND</u> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>GIBSON Hospital</u> | | Length of stay in lb <u>1 WEEK</u> | d. STREET ADDRESS (If outside, give location) <u>520 A</u> |
| | | Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

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| 3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>MADISON</u> Last <u>HEDGECOCK</u> | | | 4. DATE OF DEATH Month <u>JUNE</u> Day <u>22</u> Year <u>1958</u> | | |
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| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>OCT. 24, 1869</u> | 9. AGE (In years last birthday) <u>88</u> | IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____ | IF UNDER 24 HRS. Hours _____ Min. _____ |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HARDWARE MERCHANT</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>Adm. M.</u> | 11. BIRTHPLACE (City and state or country) <u>GENTERVILLE, IOWA</u> | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
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| 13. FATHER'S NAME <u>CYRUS HEDGECOCK</u> | 14. MOTHER'S MAIDEN NAME <u>ELIZABETH MANNING</u> |
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| 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>494-38-2994</u> | 17. INFORMANT Address <u>MRS. J. M. HEDGECOCK HURLAND, Mo.</u> |
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| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Circulatory Failure</u> <u>Prolonged Recumbency Necessitated by Gangrene of</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Left foot</u> DUE TO (c) <u>Arteriosclerosis</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |

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| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour _____ Month, Day, Year a. m. _____ p. m. _____ | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION COUNTY STATE |

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| 21. I attended the deceased from <u>July 10, 1949</u> to <u>June 22, 1958</u> and last saw her alive on <u>6/22/58</u> Death occurred at <u>9:00</u> P. m. on the date stated above; and to the best of my knowledge, from the causes stated. |
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| 22a. SIGNATURE (Degree or title) <u>[Signature] D.O.</u> | 22b. ADDRESS <u>Edina, Mo.</u> | 22c. DATE SIGNED <u>6/24/58</u> |
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| 23a. BURIAL, CREMATION REMOVAL (Specify) _____ | 23b. DTE <u>JUNE 25 '58</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>I.O.O.F</u> | 23d. LOCATION (City, town, or county) (State) <u>HURLAND Mo.</u> |
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| 24. FUNERAL DIRECTOR ADDRESS <u>Mrs. Margaret Easley, Hurland, Mo.</u> | 25. DATE RECD. BY LOCAL REG. <u>June 24 - 58</u> | 26. REGISTRAR'S SIGNATURE <u>Helle A. Humolt</u> |
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(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare & Public Service
300 1-56
All symptoms will be listed. All diseases in Part I must be causally related.
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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
Signature of Student Embalmer

Signed *Richard B. Kelly*

Licensed Embalmer No. *44*

P. O. Address *Elm*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.