SSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

MENT OF PUBLIC HEALTH AND WELFARE

-61-012882

STATE FILE NUMBER

AMENDED

FILED APR 18 1961

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 88

DATE AMENDED

1. PLACE OF DEATH
a. COUNTY Callaway
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Fulton, Missouri
Length of stay in 1b 22yr.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION State Hosp. No. 1, Fulton
Inside Limits Yes ☐ No ☒

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY St. Louis
c. CITY OR TOWN University City
Inside Limits Yes ☑ No ☐
d. STREET ADDRESS 5646 Bartmer Ave (If outside, give location)
Reside on Farm Yes ☐ No ☑

3. NAME OF DECEASED (Type or print) First: Eddie Middle: Last: Hedges
4. DATE OF DEATH Month 4 Day 10 Year 61
5. SEX male
6. COLOR OR RACE white
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH 1889
9. AGE (last birthday) 72
IF UNDER 1 YEAR Months Days
IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none
10b. KIND OF BUSINESS OR INDUSTRY none
11. BIRTHPLACE (City and state or country) Illinois
12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME Francis Hedges
13b. MOTHER'S MAIDEN NAME Mary ??
14. NAME OF HUSBAND OR WIFE none
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no
16. SOCIAL SECURITY NO. none
17. INFORMANT State Hosp. records. Address

INSTEAD OF

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) GI Bleeding Hiatus Hernia
DUE TO (c) Cerebral Palsy
INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from State Hospital No. 1 2/7/61 to 4/10/61 and last saw him alive on xxxxxxxxxxxxxx
Death occurred at 1255 PM m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE William V Torricelli (Degree or title) M.D.
22b. ADDRESS Fulton St. Hosp
22c. DATE SIGNED 4/11/61

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal
23b. DATE 10 April 1961
23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery
23d. LOCATION (City, town, or county) St. Louis (State) Mo.
24. FUNERAL DIRECTOR Birmingham ADDRESS Vienna Mo.
25. DATE RECD. BY LOCAL REG. April-10-1961
26. REGISTRAR'S SIGNATURE Marietta Lawrence

(Licensed Embalmer's Statement on Reverse Side)

**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_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No. 4996

P. O. Address Fulton, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl 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.