

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-031946

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

042

1000

985

STATE FILE NUMBER

Registration District No.

Primary Registration District No.

Registrar's No.

AMENDED

FILED OCT 9 1961

1. PLACE OF DEATH a. COUNTY <b>Euchanan</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Euchanan</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph, Missouri</b>		Length of stay in 1b <b>Most of Life</b>	c. CITY OR TOWN <b>St. Joseph, Missouri</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>(Home) 5507 King Hill Ave.</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>5507 King Hill Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>H.</b> Last <b>HEDRICK</b>			4. DATE OF DEATH Month <b>September</b> Day <b>22</b> Year <b>1961</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>May 19, 1874</b>	9. AGE (last birthday) <b>87</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Grocerman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hedrick Grocery Store Salem, Illinois</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Daniel T. Hedrick</b>		13b. MOTHER'S MAIDEN NAME <b>Nancy Swan</b>		14. NAME OF HUSBAND OR WIFE <b>Lillie M. Hedrick</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			17. INFORMANT Address <b>George D. Hedrick So. St. Paul, Minn.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Arteriosclerotic heart Disease</b>					INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Generalized arteriosclerosis</b> <b>indefinite</b>					
DUE TO (c)					
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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	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 <b>2:00 PM</b> Month, Day, Year					
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	
21. I attended the deceased from <b>Sept. 21, 1961</b> to <b>Sept. 21, 1961</b> and last saw him alive on <b>Sept. 21, 1961</b> . Death occurred at <b>2:00 PM</b> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>H. F. Mundy MD</b>			22b. ADDRESS <b>St. Joseph Mo</b>		22c. DATE SIGNED <b>Sept 26-1961</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Sept. 26, 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Ashland Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Joseph, Missouri</b>		
24. FUNERAL DIRECTOR ADDRESS <b>Meierhoffer-Fleeman Inc., St. Joseph, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>Sept. 30, 1961</b>	26. REGISTRAR'S SIGNATURE <b>Wm. Clark Sandell</b>		

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

H. F. Mundy, M.D. MEDICAL CERTIFICATION

**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 Albert B. Harrington

Licensed Embalmer No. 3258

P. O. Address St. Joseph

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.