

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-041779

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 217

Primary Registration District No. 5786

Registrar's No. 82

AMENDED

**FILED DEC 5 1961**

DATE AMENDED

INSTEAD OF

DOCUMENT

1. PLACE OF DEATH a. COUNTY <b>Mississippi</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Mississippi</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Charleston</b>	Length of stay in 1b <b>Life</b>	c. CITY OR TOWN <b>Charleston</b>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS <b>Rt. 3</b> (If outside, give location)	Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Rev. Jessie</b> Middle <b>Hedgman</b> Last <b>Hedgman</b>	4. DATE OF DEATH Month <b>Nov.</b> Day <b>26,</b> Year <b>1961</b>
---	---

5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</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>1/26/1891</b>	9. AGE (last birthday) <b>70</b>	IF UNDER 1 YEAR Months <b>10</b> Days	IF UNDER 24 HR Hours Min.
--------------------	-------------------------------	--	-----------------------------------	----------------------------------	--	------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farm Hand</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Birds Mill Mo.</b>	11. BIRTHPLACE (City and state or country) <b>U.S.A.</b>	12. CITIZEN OF WHAT COUNTRY
--	---	--	-----------------------------

13a. FATHER'S NAME <b>Jessie Hedman</b>	13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	14. NAME OF HUSBAND OR WIFE
---	--	-----------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Dr. Neal Parker</b> Address <b>Charleston Mo. Rt. 3</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>Acute Coronary Occlusion</b>	INTERVAL BETWEEN ONSET AND DEATH <b>6 Hrs.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Hypertensive Cardiovascular Disease</b>	<b>Unkn.</b>
DUE TO (c) <b>Generalized Arteriosclerosis</b>	<b>Unkn.</b>

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 . . . . . a.m. . . . . p.m. . . . .	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 11/1861 to 11/26/61 and last saw <sup>her</sup>him alive on 11/26/61  
Death occurred at 1230 Am on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>John L Sample</i> (Describe or title) <b>M.D.</b>	22b. ADDRESS <b>204 Locust St. Charleston Mo.</b>	22c. DATE SIGNED <b>12/2/61</b>
---	---	---------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>12/2/1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove Cem.</b>	23d. LOCATION (City, town, or county) <b>Charleston Mo.</b> (State)
---	----------------------------	--	---

24. FUNERAL DIRECTOR <b>Peoples Charleston Mo.</b> ADDRESS	25. DATE RECD. BY LOCAL REG. <b>12-2-61</b>	26. REGISTRAR'S SIGNATURE <i>Sorathy B Hathorn</i>
--	---	--

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

DEC 19 1961

DEC 6 1961

**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 Willie R. Davis

Licensed Embalmer No. 5129

P. O. Address Charleston

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.