

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-010324

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 27 Primary Registration District No. 3005 Registrar's No. 13 STATE FILE NUMBER

**FILED MAR 26 1963**

|   |   |  |   |
|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Bates</u>   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Mo</u> b. COUNTY <u>ST. CLAIR</u>                   |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>BUTLER</u> Length of stay in lb <u>1 mo</u>  |   | c. CITY OR TOWN <u>Appleton City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                   |   |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Bates Co. M. Hosp</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |   | d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>                                    |   |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>SILVESTER BURR Hedrick</u>   |   |  | 4. DATE OF DEATH Month Day Year <u>Mar 15 1963</u>  |
| 5. SEX <u>M</u>   | 6. COLOR OR RACE <u>W</u>   | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>Jan 28-78</u>   |
| 9. AGE (last birthday) <u>85</u>  |   | IF UNDER 1 YEAR Months <u>1</u> Days <u>17</u>   | IF UNDER 24 HR Hours <u></u> Min. <u></u>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Peace Officer</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY <u></u>  | 11. BIRTHPLACE (City and state or country) <u>BATLER, Mo.</u>   |
| 12. CITIZEN OF WHAT COUNTRY <u>USA</u>  |   | 13a. FATHER'S NAME <u>C.O. HEDRICK</u>   |   |
| 13b. MOTHER'S MAIDEN NAME <u>MARTHA Deems</u>   |   | 14. NAME OF HUSBAND OR WIFE <u>none</u>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u></u>  |   | 16. SOCIAL SECURITY NO. <u></u>  |   |
| 17. INFORMANT <u>JOHN HEDRICK</u>   |   | Address <u>3311 S. Elm Denver, Colo.</u>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u>   |   |  | INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u>  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause, last. DUE TO (b) <u>Influenza</u>   |   |  | <u>10 days</u>  |
| DUE TO (c) <u></u>  |   |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>senile dementia</u>  |   |  | 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 <u></u> a.m. <u></u> p.m. <u></u> Month, Day, Year <u></u>   | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 <u>Feb 15-63</u> to <u>3-15-63</u> and last saw him alive on <u>3-15-63</u> . Death occurred at <u></u> m on the date stated above, and to the best of my knowledge, from the causes stated. |   |  |   |
| 22a. SIGNATURE (Degree or title) <u>R. L. Hansen MD</u>   |   | 22b. ADDRESS <u>Butler MO.</u>   | 22c. DATE SIGNED <u>3-17-63</u>   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>   | 23b. DATE <u>3-17-63</u>  | 23c. NAME OF CEMETERY OR CREMATORY <u>Appleton City</u>  | 23d. LOCATION (City, town, or county) (State) <u>Appleton City Mo.</u>  |
| 24. FUNERAL DIRECTOR ADDRESS <u>Wesley Eckhoff Appleton City, Mo.</u>   |   | 25. DATE REGD. BY LOCAL REG. <u>3-16-63</u>  | 26. REGISTRAR'S SIGNATURE <u>Norma Jean Wilson</u>  |

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DATE AMENDED  
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
INSTEAD OF  
DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF  
ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

**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 Oscar E. Hoff

Licensed Embalmer No. 3942

P. O. Address Appleton City, Ind.

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.