

MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH

242

85

File No. _____
Registered No. 58
St. _____ Ward _____

1. PLACE OF DEATH

County Bureau
Township _____
City St. Joseph

Registration District No. _____

Primary Registration District No. 1001

2. FULL NAME

Mary Ann Hedges

(a) Residence. No. _____

(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. 9 mos. 16 ds.

Ward. _____

(If nonresident, give city or town and State)

How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF L

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 22 1889

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
40 9 23

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Female State Hosp.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) West Virginia

(STATE OR COUNTRY) West Virginia

PARENTS

10. NAME OF FATHER Ed. Hedges

11. BIRTHPLACE OF FATHER (CITY OR TOWN) West Virginia

(STATE OR COUNTRY) West Virginia

12. MAIDEN NAME OF MOTHER Mary Ann Hedges

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) West Virginia

(STATE OR COUNTRY) West Virginia

14.

INFORMANT Hosp. Records

(Address) State Hosp #2 St. Joseph Mo.

15.

FILED 16 1931

REGISTRAR Ed.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) January 15 1931

17. I HEREBY CERTIFY, That I attended deceased from May 5, 1929, to January 15, 1931 that I last saw h. alive on January 15, 1931, and that death occurred, on the date stated above, at 5 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Intestinal Obstruction

177 B

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY Unobstructed sigmoid (SECONDARY)

(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH at place of death

DID AN OPERATION PRECEDE DEATH? No DATE OF L

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS Autopsy + clinical findings

(Signed) George W. Forman, M. D.

Jan 16, 1931 (Address) State Hosp #2 St. Joseph Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Memorial Park

Jan 16 1930

20. UNDERTAKER

ADDRESS

Fluman Funeral Home Calhoun

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

