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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 22 1948

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 32657

Registration District No. 228

Primary Registration District No. 5468

Registrar's No. 886

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Rural Taylor Sup
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Stratford, Rt. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 74 years (Specify whether)
years, months or days

3. (a) PRINT FULL NAME Dora Inej Headlee

3. (b) If veteran, name war No 3. (c) Social Security No. No

4. Sex F / 5. Color or race W
6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife J. W. Headlee 6. (c) Age of husband or wife if alive 28 years
7. Birth date of deceased Nov. 1870
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>77</u>	<u>10</u>	<u>15</u>	hr. _____ min.

9. Birthplace Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business Housewife

12. Name David Kesterson

13. Birthplace Ohio
(City, town, or county) (State or foreign country)

14. Maiden name Minerva Ketcherside

15. Birthplace Georgia
(City, town, or county) (State or foreign country)

16. (a) Informant James H. Headlee

(b) Address Stratford, Rt. 1

17. (a) Burial (b) Date thereof 10-16-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Comfort

18. (a) Signature of funeral director J. W. Klingner & Co.

(b) Address Springfield, Mo.

19. (a) 10-15-48 (b) W. H. Handley
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Stratford, Rt. 1
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 13
year 1948 hour 3 minute 10 P.M.

21. I hereby certify that I attended the deceased from Sept 15
1948 to 10-10, 1948
that I last saw her alive on 10-11, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage
Due to Arterio Sclerosis

Other conditions Senility
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place) _____
While at work? _____ (e) Means of injury _____

23. Signature C. E. Feller (M. D. or other) _____
Address Springfield, Mo. Date signed 10/14/48

Duration
1 da
3 1/2
PHYSICIAN
Underline the cause to which death should be charged statistically.

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Ogdi Stone Jr.

Licensed Embalmer No. *4176*

P. O. Address.....

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 this body is not embalmed, fact should be so stated above.