

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH

10162
 Do not use this space.

1. PLACE OF DEATH

(a) County Buchanan Registration District No. 85
 (b) Township Washington Primary Registration District No. 1001 Registered No. 320
 (c) City St. Joseph Mo. (d) Street No. Mo. Methodist Hospital St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. _____ St. Altamont Mo.
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Stella Redman</u>				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Sept 11 1869</u>				
7. AGE		YEARS <u>69</u>	MONTHS <u>6</u>	DAYS <u>14</u>
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>Farmer</u>				If LESS than 1 day, _____ hrs. or _____ min.
9. Industry or business in which work was done, as saw mill, bank, etc.		11. Total time (years) spent in this occupation <u>0</u>		
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>DeKalb Co Ga</u>				
13. NAME <u>John Redman</u>				
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>unknown Mo.</u>				
15. MAIDEN NAME <u>Mary - unknown</u>				
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>unknown Ky</u>				
17. INFORMANT (ADDRESS) <u>Mrs Stella Redman Altamont Mo.</u>				
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Altamont Mo.</u> DATE <u>3/25 39</u>				
19. FUNERAL DIRECTOR (ADDRESS) <u>O. Moore Cameron Mo.</u>				
20. FILED <u>MAY 25 1939</u> <u>H. J. Heddbush</u> Local Registrar.				

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 25 1939

22. I HEREBY CERTIFY, That I attended deceased from Mar 21, 1939, to Mar 25, 1939
 I last saw him alive on Mar 25, 1939 Death is said to have occurred on the date stated above, at 9:30 A.M.
 The principal cause of death and related causes of importance were as follows:
Pneumonia Date of onset 3-22-39

Other contributory causes of importance:
Arthritis Chronic Don't know
Chronic Endocarditis 10 yr
Chronic Myocarditis 6 yr

Name of operation None Date of _____
 What test confirmed diagnosis? E. & T. Lab. Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No
 If so, specify _____
 (Signed) E. M. Shores, M. D.
 (Address) 317 1/2 Linkpatrick Bldg St. Joseph Mo.

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

FORM 1 X12004

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.

92a

STATEMENT BY LICENSED EMBALMER

I, O. Moore , Licensed Embalmer No. 1180

hereby certify that the body recorded on the reverse side of this certificate was embalmed by O. Moore

L. E. _____

No. _____ or by _____, Registered Apprentice No. _____

working under my personal supervision.

Signed O. Moore

Licensed Embalmer No. 1180

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.)

RECEIVED BY THE BOARD OF HEALTH OF THE CITY OF BOSTON

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

10167
Do not use this space.

1. PLACE OF DEATH

(a) County Duchanan Registration District No. 85-
 (b) Township _____ Primary Registration District No. 1001 Registered No. 320
 (c) City St Joseph (d) Street No. _____ St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Robert Redman
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>m</u>	4. COLOR OR RACE <u>w</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>m</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR)		
7. AGE	YEARS <u>69</u>	MONTHS <u>6</u>
	DAYS <u>14</u>	IF LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.	
	9. Industry or business in which work was done, as saw mill, bank, etc.	
	10. Date deceased last worked at this occupation (month and year)	11. Total time (years) spent in this occupation
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)		
FATHER	13. NAME	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)	
MOTHER	15. MAIDEN NAME	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)	
17. INFORMANT (ADDRESS)		
18. BURIAL, CREMATION, OR REMOVAL		
PLACE	DATE	19
19. FUNERAL DIRECTOR (ADDRESS)		
20. FILED _____ 19 _____		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-25-1939

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____ to _____, 19____
 I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.
 The principal cause of death and related causes of importance were as follows:
Pneumonia Broncho
Arthritis chr
Endocarditis chr
Myocarditis chr
 Other contributory causes of importance:
 Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?
 If so, specify _____
 (Signed) E. M. Shore, M. D.
 (Address) St Joseph Mo

Date of onset 3-22-39
unk
unk
unk

SUPPLEMENTARY

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

Local Registrar.

1949-50