

DEC 12 1940 **827**

Registration District No. **827**

Primary Registration District No. **4500**

Registrar's No. **28**

1. PLACE OF DEATH:

(a) County Shelby
(b) City or town Clarence
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2
In this community all his life (Specify whether years, months or days) 2

3. (a) PRINT FULL NAME Byers Lee Redings

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

4. Sex male 5. Color or race or 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife ✓ 6. (c) Age of husband or wife if alive ✓ years _____

7. Birth date of deceased July 2 - 1864
(Month) (Day) (Year)

8. AGE: Years 76 Months 18 Days 5 If less than one day hr. _____ min. _____

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

10. Usual occupation carpenter

11. Industry or business 1

12. Name P. F. Redings

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

14. Maiden name Annus Hallerman

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

16. (a) Informant Eliza Davis

(b) Address Clarence Mo.

17. (a) Burial (b) Date thereof Nov 9 - 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Salmon

18. (a) Signature of funeral director W. C. Hopper

(b) Address Clarence Mo.

19. (a) Dec 10 - 1940 (b) Ray Hamilton
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Shelby

(c) City or town Clarence
(If outside city or town limits, write "RURAL")

(d) Street No. 0
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov - 7th day 7th
year 1940 hour 5 minute 0 M.

21. I hereby certify that I attended the deceased from at home
from 1930, to Nov. 14, 1940
that I last saw him alive on _____, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Acute Myocardial Infarction

Due to _____

Chronic Bronchitis

Due to _____

Other conditions (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? _____

75 75 While at work? _____ (Specify type of work) Means of injury _____

23. Signature Frank K. Ray (M. D. or other) 1
Address Clarence, Mo. Date signed 12/6-40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 10

District File Number 12-40-2277

Date Filed DEC 11 1940

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.....

Licensed Embalmer No.....

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, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 39929

Registration District No. 827

Primary Registration District No. 4500

Registrar's No. _____

1. PLACE OF DEATH:

- (a) County Shelby
- (b) City or town Clarevue
(If outside city or town limits, write "RURAL" and name of township)
- (c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

3. (a) PRINT FULL NAME Cyrus Lee Ridings

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

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced s

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ year _____

7. Birth date of deceased (Month) _____ (Day) _____ (Year) _____

8. AGE: Years 76 Months 4 Days 5 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name P. J. Ridings

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

14. Maiden name _____ (State or foreign country) _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof (Month) _____ (Day) _____ (Year) _____

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 12-10-1940 (b) Ray Hamilton
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____ (If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

20. DATE OF DEATH Month Nov day 1
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that last saw h_____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____ Duration _____

Due to _____

Due to _____

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

Major findings: Of operations _____ PHYSICIAN _____

Of autopsy _____ Underline the cause to which death should be charged statistically.

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? _____

While at work? _____ (Specify type of place) _____ (e) Means of injury _____

23. Signature Frank R. Ray (M. D. or other) _____

Address Clarevue m. Date signed _____

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

MOTHER FATHER

RECEIVED SUPPLEMENTAL

1940

S-39929