

S. No. 2
-11-10-39
5-17-39
PI X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 42448

Registration District No. 293

Primary Registration District No. 5411

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Leaslipin B. 11-7
(b) City or town Gray Summit
(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 7 years _____ (Specify whether)
years, months or days _____

3. (a) PRINT FULL NAME William C. Redhage

3. (b) If veteran, name war no 8. (c) Social Security No. none

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

6. (b) Name of husband or wife Bertha Redhage 6. (c) Age of husband or wife if alive 49 years

7. Birth date of deceased Jan. 12, 1890
(Month) (Day) (Year)

8. AGE: Years 50 Months 11 Days 10 If less than one day _____ hr. _____ min.

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

10. Usual occupation Laborer

11. Industry or business _____

FATHER { 12. Name Louis Redhage

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

MOTHER { 14. Maiden name unknown

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

16. (a) Informant Mrs. Bertha Redhage

(b) Address Gray Summit Mo

17. (a) Burial (b) Date thereof 12/24/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Augustines

18. (a) Signature of funeral director Wm. E. Brubaker
(b) Address Pacific Mo 266

19. (a) 12-25-40 (b) Mary B. Ross
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Franklin
(c) City or town Gray Summit
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A. ✓ _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 22
year 1940 hour 5 minute 20 A. M.

21. I hereby certify that I attended the deceased from Dec. 15, 1940, to Dec. 22, 1940
that I last saw him alive on Dec. 18, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Bronchitis
Due to Bronchiectasis 5 years.
Scilicosis 9 years 8
10 1/2 years.

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

Major findings: Of operations ✓
Of autopsy ✓

Duration
5 years.
9 years 8
10 1/2 years.
PHYSICIAN
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 Wm. E. Brubaker (M. D. or other) ✓
Address Pacific Mo. Date signed 12-27-40

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 _____

August Brown Jr., Registered Apprentice No. 261
working under my personal supervision.

Signed _____

Licensed Embalmer No. 3008

P. O. Address Pacific M

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.