

FILED SEP 24 1942

Registration District No. 149

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: K. C. General Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 Hrs. (Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 4305 Walnut St.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Felix Paul Reddick

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

4. Sex Male 5. Color or race W. 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Grace D. Reddick 6. (c) Age of husband or wife if alive 49 years
7. Birth date of deceased Aug. 23rd (Month) (Day) (Year)

8. AGE: Years 52 Months 0 Days 24 If less than one day _____ hr. _____ min.

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

10. Usual occupation Barber

11. Industry or business _____

MOTHER FATHER { 12. Name J. W. Reddick
13. Birthplace Illinois (City, town, or county) (State or foreign country)
14. Maiden name Mary Green
15. Birthplace Arkansas (City, town, or county) (State or foreign country)

16. (a) Informant Record Clerk
(b) Address K. C. General Hospital

17. (a) Burial (b) Date there Sept-20-42 (Month) (Day) (Year)

(c) Place: burial or cremation See Summit

18. (a) Signature of funeral director W. P. Thompson

(b) Address See Summit

19. (a) 9/18/42 (b) M. M. Crow (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 17th
year 1942 hour 3 minute 10 P. M.

21. I hereby certify that I attended the deceased from 9-17-42, 1942, to 9-17-42, 1942,
that I last saw him alive on 9-17-42, 1942,
and that death occurred on the date and hour stated above.

Immediate cause of death MASSIVE CEREBRAL HEMORRHAGE
Due to 822
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: _____
Of operations _____
Of autopsy See above

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)
(2) Means of injury _____
Signature Wm. R. Thom (M. D. or other)
Med. Dir. K.C. Gen. Hospital
Address _____ Date signed _____

Duration

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

W. B. Langford

Licensed Embalmer No.

3833

P. O. Address

Summit N.

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. _____

Registration District No. _____

Primary Registration District No. _____

Registrar's No. 3436

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

1. PLACE OF DEATH:

(a) County _____
(b) City or town _____
(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 17 yrs years, months or days

3. (a) PRINT FULL NAME Felix Paul Reddick

3. (b) If veteran, name war no 3. (c) Social Security No. 486-10-5685

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

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

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

8. AGE: Years 52 Months _____ Days _____ If less than one day _____ hr _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

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

14. Maiden name _____ (City, town, or county) (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)

(Burial, cremation, or removal) (Place: burial or cremation)

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 9/26/42 (b) M. M. Browne (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) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 17 year 1942 hour _____ minute _____ M.

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

Immediate cause of death _____

Due to _____

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? _____

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

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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