

FILED JAN 15 1944

Registration District No. 146

Primary Registration District No. 5568

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

1. PLACE OF DEATH:

(a) County JACKSON

(b) City or town BLUE RURAL Blue Hill
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
35th & DENTON ROAD
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community 2 YEARS years, months or days

2. USUAL RESIDENCE OF DECEASED: 48

(a) State MISSOURI (b) County JACKSON

(c) City or town RURAL Kansas City
(If outside city or town limit, write "RURAL")

(d) Street No. 35th & DENTON ROAD
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME CORA BELL PEDICORD

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

4. Sex FEMALE / race WHITE

5. Color or 1 race WHITE

6. (a) Single, widowed, married, 2 divorced WIDOWED

6. (b) Name of husband or wife A. SANFORD PEDICORD

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

7. Birth date of deceased DEC 1 1873
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>70</u>	<u>0</u>	<u>13</u>	hr. _____ min.

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

10. Usual occupation AT HOME

11. Industry or business _____

MOTHER FATHER { 12. Name T. E. MILLER

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

14. Maiden name EMMA JEWETT

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

16. (a) Informant ROY PEDICORD

(b) Address 35th DENTON ROAD, K.C., Mo.

17. (a) BURIAL (b) Date thereof DEC 17 '43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation RAYMORE, MO.

18. (a) Signature of funeral director F. K. GEORGEY SONS

(b) Address BELTON, Mo.

19. (a) 12-17-1943 (b) James W. Ross
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month DEC day 14
year 1943 hour 4 minute 04 P.M.

21. I hereby certify that I attended the deceased from DEC 1 1943 to DEC 14 1943
that I last saw her alive on DEC 14 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial Pneumonia Duration 14 days

Due to Uremia & senile dementia

Due to _____

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

PHYSICIAN _____

Major findings: Of operations _____

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? _____

(Specify type of place) _____ (e) Means of injury _____

While at work? ✓

23. Signature R. L. Haffoon (M. D. or other) _____

Address Raytown Mo Date signed 12-16-43

116

*James W. Lane
531 E. College
Sand Springs, Mo.*

FEB 3 1954

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 *A. K. George*
Licensed Embalmer No. *3645*
P. O. Address *Sandwich, Mo.*

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Jan
Registrar's No. 317

Registration District No. 146 Primary Registration District No. 5568

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

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Rural Blue Jay
(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) (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Carroll Redwood
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced W
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Dec 1 1875
(Month) (Day) (Year)

8. AGE: Years 70 Months 0 Days _____ If less than one day _____ min.

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

16. (a) Informant _____
(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) _____ (b) _____
(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 _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Dec year 1943 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____ to _____, 19____
that I last saw him _____ alive on _____, 19____
and that death occurred on the date and hour stated above.
Immediate cause of death Wrenn

Due to chronic senile dementia
Due to hypertension
Other due to mental condition
(Include pregnancy within 6 months of death)

Major findings:
Of operations _____
Of autopsy 122.2

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) (a) Means of injury _____
23. Signature J. H. Hopper (M. D. or other) _____
Address Raytown Mo Date signed 1-12-44

SUPPLEMENTAL

MENTARY

Duration 17 da
PHYSICIAN
Underline the cause to which death should be charged statistically.

S-342555