

FILED AUG 23 1944

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 3357

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 days  
(Specify whether years, months or days)

In this community 20 yrs.

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. 3633 Fairmont  
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Charles B. Redman

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 13  
year 1944 hour 8 minute 30 A.M.

3. (b) If veteran, name war no

3. (c) Social Security No. No Record

21. I hereby certify that I attended the deceased from August 6 1944 to August 13 1944  
that I last saw him alive on August 13 1944  
and that death occurred on the date and hour stated above.

4. Sex M Color W

5. Color or race W

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

6. (c) Age of husband or wife if alive 32 years

7. Birth date of deceased: July 26, 1884  
(Month) (Day) (Year)

Immediate cause of death Myocardial infarction

Duration \_\_\_\_\_

8. AGE: Years 59 Months 11 Days 17  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Due to \_\_\_\_\_

Due to 9/4a

9. Birthplace No Record  
(City, town, or county) (State or foreign country)

10. Usual occupation Credit mgr. Ret.

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name Redman

13. Birthplace No Record  
(City, town, or county) (State or foreign country)

14. Maiden name No Redman

15. Birthplace No Record  
(City, town, or county) (State or foreign country)

Major findings: Of operations \_\_\_\_\_

Of autopsy None

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant Freida Redman

(b) Address 3633 Fairmont

17. (a) Burial (b) Date there Aug 15-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director Harlyn Ross

(b) Address 7406 W. 44th

19. (a) 8-14-44 (b) D. E. Brown  
(Date received from registrar) (Registrar's signature)

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)

(c) Method of injury \_\_\_\_\_

23. Signature A. E. Warner (M. D. or other) MD.  
Address Med. Dir. Gen'l Hosp. Date signed 8-14-44

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

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**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 *Harlyn Rose*  
Licensed Embalmer No. *2810*  
P. O. Address *H. C. ...*

**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.**