

FILED DEC 4 1944

Registration District No. 1949

Primary Registration District No. 1002

Registrar's No. 4647

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

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 4 days  
(Specify whether 0)

In this community Do not know  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 42

(c) City or town Kansas City  
(If outside city or town limits, write "RURAL") 3

(d) Street No. 548 Main  
(If rural, give location) 9

(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country 0

3. (a) PRINT FULL NAME Charles Redding

3. (b) If veteran, name war Do not know

3. (c) Social Security No. Do not know

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

6. (b) Name of husband or wife Do not know 6. (c) Age of husband or wife if alive Do not know years

7. Birth date of deceased Do not know  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
<u>About 60</u>				hr. min.

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

10. Usual occupation unknown

11. Industry or business unknown

12. Name unknown 9

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

14. Maiden name unknown 9

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

16. (a) Informant General Hospital

(b) Address K. C. MO

17. (a) Burial (b) Date thereof 11-20-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation McClary R.C.R.

18. (a) Signature of funeral director John P. ...

(b) Address 6506 ...

19. (a) 11-18-44 (b) T. C. Brown (JR)  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 17  
year 1944 hour 7 minute 20 A. M.

21. I hereby certify that I attended the deceased from Nov. 13, 1944, to Nov. 17, 1944  
that I last saw him alive on Nov. 17, 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration

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

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

Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations 83a

Of autopsy None

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 MO

23. Signature A. E. ... (M. D. or D.O.) MO

Address Med. Dir. Gen'l Hosp. Date signed 11-17-44

**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.....

*John J. Shiel*

Licensed Embalmer No.....

*3825*

P. O. Address.....

*K. C. Va.*

**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.**