S. No. 2
DM—5-43
v. 5-17-39
o I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED AUG 4 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 23162

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3102

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: Trinity Lutheran Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10 days (Specify whether
In this community 28 yrs years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Jackson 48
(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")
(d) Street No. 4130 Walnut 8
(If rural, give location) 0
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Lionel V. Redpath
3. (b) If veteran, name war None
3. (c) Social Security No. None
4. Sex Male
5. Color or race W
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Mabel E. Redpath
6. (c) Age of husband or wife if alive 66 years
7. Birth date of deceased Aug 7 1869 (Month) (Day) (Year)

8. AGE: Years 75 Months 11 Days 16 If less than one day hr. min.

9. Birthplace Thompston Conn (City, town, or county) (State or foreign country)
10. Usual occupation advertising
11. Industry or business Publishing
FATHER
12. Name no Record
13. Birthplace no Record a (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name no Record
15. Birthplace no Record a (City, town, or county) (State or foreign country)
16. (a) Informant Mabel E. Redpath
(b) Address 4130 Walnut
17. (a) Cremation (Burial, cremation, or removal) (b) Date thereof July 26-1945 (Month) (Day) (Year)
(c) ~~Place of Burial~~ or cremation Elmwood Cem
18. (a) Signature of funeral director Mrs C. L. Foster
(b) Address 918 Brooklyn
19. (a) 7-24-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 23 year 1945 hour minute 10:30 P.M.
21. I hereby certify that I attended the deceased from 7/14, 1945 to 7/23, 1945 that I last saw him alive on 7/23, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral Hemorrhage	9 days
Due to: Arteriosclerosis	4 yrs
Due to:	
Other conditions: ✓ (Include pregnancy within 3 months of death)	
Major findings: Of operations ✓ 8 30	
Of autopsy ✓	

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? (Specify type of place)
While at work? (e) Means of injury
23. Signature J. Tarr (M. D. or other) M.D.
Address 8 J T Ralls Date signed 7/24/45

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No. 3414

P. O. Address 918 Brooklyn

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.