

FILED SEP 19 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 29365

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

BIRTH NO. _____		REG. DIST. NO. <u>42</u>		PRIMARY REG. DIST. NO. <u>1000</u>		Registrar's No. <u>970</u>	
1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u>		c. LENGTH OF STAY (in this place) <u>13 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Missouri Methodist Hosp</u>				d. STREET ADDRESS (If rural, give location) <u>423 N. 17th</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Selma</u>		b. (Middle) <u>Bertha</u>		c. (Last) <u>Redding</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 3 1949</u>	
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>		8. DATE OF BIRTH <u>June 24, 1881</u>	
9. AGE (In years last birthday) <u>68</u>		IF UNDER 1 YEAR Months <u>2</u> Days <u>9</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Berlin, Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13a. FATHER'S NAME <u>Frederick Schimelfenig</u>			13b. MOTHER'S MAIDEN NAME <u>unknown</u>			14. NAME OF HUSBAND OR WIFE <u>John Thomas Redding</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>John T. Redding St. Joseph, Mo.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Peritonitis</u>					
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause. (a) stating the underlying cause last. DUE TO (b) <u>Gangrene of Cecum</u> DUE TO (c) <u>Arterio Sclerosis general</u>					
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Syphilitic atherosclerosis</u> <u>Sub diaphragmatic abscess</u>				<u>578</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>Gangrene of Cecum</u>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug 22, 1949</u> , to <u>Sept 3, 1949</u> , that I last saw the deceased alive on <u>Sept 3, 1949</u> , and that death occurred at <u>4:20 P.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>H. Thompson M.D.</u>				23b. ADDRESS <u>902 Edmond St. Joseph</u>		23c. DATE SIGNED <u>9-6-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <u>9-6-1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Mora</u>		24d. LOCATION (City, town, or county) (State) <u>St. Joseph Mo.</u>	
DATE REC'D BY LOCAL REG. <u>Sept. 10, 1949</u>		REGISTRAR'S SIGNATURE <u>E. C. Jenkins</u>		382		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Walter Bowman Funeral Home St. Joseph Mo.</u>	

Dr. John R. McDaniel

**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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed William Galbraith

Licensed Embalmer No. 4535

P. O. Address 319 S. 10th St. St. Joseph, 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, fact should be so stated above.