

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

62-031715

STATE FILE NUMBER

Registration District No. 385- Primary Registration District No. 3039 Registrar's No. 176

DO NOT WRITE ON THIS STUB

AMENDED

FILED SEP 6 1962	
<p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>Linn</u></p> <p>b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Marceline</u> Length of stay in 1b <u>13 days</u></p> <p>c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Francis Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE <u>Missouri</u> b. COUNTY <u>Linn</u></p> <p>c. CITY OR TOWN <u>Brookfield</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p>d. STREET ADDRESS (if outside, give location) <u>809 W. Dake St.</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>3. NAME OF DECEASED (Type or print) First Middle Last <u>EFFIE MAY REDDING</u></p>	
<p>4. DATE OF DEATH Month Day Year <u>August 29, 1962</u></p>	
<p>5. SEX <u>F</u></p>	<p>6. COLOR OR RACE <u>W</u></p>
<p>7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <u>11-23-1876</u> 9. AGE (last birthday) <u>85</u></p>
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u></p>	<p>10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u></p>
<p>11. BIRTHPLACE (City and state or country) <u>St. Catherine, Mo.</u></p>	<p>12. CITIZEN OF WHAT COUNTRY <u>USA</u></p>
<p>13a. FATHER'S NAME <u>Wesley Lineberry</u></p>	<p>13b. MOTHER'S MAIDEN NAME <u>Waconda Langwell</u></p>
<p>14. NAME OF HUSBAND OR WIFE <u>John H. Redding</u></p>	
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)</p>	<p>16. SOCIAL SECURITY NO. <u>None</u></p>
<p>17. INFORMANT Address <u>Mrs. George Ross, Brookfield, Mo.</u></p>	
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis Progressive</u></p> <p>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic Cardiovascular Disease</u></p> <p>DUE TO (c) _____</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Infra capsular Fr. Rt Femur Nov 1961</u></p> <p>PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>	
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	<p>20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/></p>
<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)</p>	
<p>20c. TIME OF INJURY Hour Month, Day, Year</p>	
<p>20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/></p>	<p>20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>
<p>20f. CITY, TOWN, OR LOCATION COUNTY STATE</p>	
<p>21. I attended the deceased from <u>1957</u> to <u>8-29-62</u> and last saw her/him alive on <u>8-28-62</u></p> <p>Death occurred at <u>7:00 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.</p>	
<p>22a. SIGNATURE (Degree or title) <u>[Signature]</u></p>	<p>22b. ADDRESS <u>Marceline, Missouri</u></p>
<p>22c. DATE SIGNED <u>8-29-62</u> (State)</p>	
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u></p>	<p>23b. DATE <u>8-31-1962</u></p>
<p>23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u></p>	<p>23d. LOCATION (City, town, or county) <u>Brookfield, Mo.</u></p>
<p>24. FUNERAL DIRECTOR ADDRESS <u>Wright Funeral Home, Brookfield, Mo.</u></p>	<p>25. DATE RECD. BY LOCAL REG. <u>8-30-62</u></p>
<p>26. REGISTRAR'S SIGNATURE <u>[Signature]</u></p>	

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

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 _____
Signature of Student Embalmer

Signed Harold B. Wright

Licensed Embalmer No. 3718

P. O. Address Brookfield, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.