

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

10582

1. PLACE OF DEATH

County Jackson
Township Raw
City N.C. Mo. (No. 3742 Park)

Registration District No. 399
Primary Registration District No. 1002

File No. _____
Registered No. 10582
St. _____ Ward _____

2. FULL NAME

Thomas S. Redman

(a) Residence, No. 3742 Park, St. 13 Ward _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

wh.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

Lizzie Redman

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

July 6 - 1890

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>58</u>	<u>7</u>	<u>26</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Painter
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Ohio

10. NAME OF FATHER

C. W. Redman

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) West Virginia

12. MAIDEN NAME OF MOTHER

Cynthia Wilson

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Virginia

14.

INFORMANT Blanche Smith
(Address) 3742 Park

15.

FILED 3/4 29 M. M. Corome
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-2-1929

17. I HEREBY CERTIFY, That I attended deceased from March 2, 1929, to March 2, 1929, that I last saw him alive on March 2, 1929, and that death occurred, on the date stated above, at 7:10 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral apoplexy
9:20 P.M.
7401
(duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY Hypertension
(SECONDARY) _____
(duration) 1 yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) John P. Lewis, M. D.
3-2-29, 1929 (Address) 5576 Indiana

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
<u>Mountain Grove, Mo.</u>	<u>March 4, 1929</u>
20. UNDERTAKER	ADDRESS
<u>Mrs. L. S. Foster</u>	<u>City</u>

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

69
2
2
2

RECORD

1000 / 1-100
1000 / 1-100
1000 / 1-100