

No. 2
1/47
17-39

FILED DEC 1 1947
Registration District No.

Primary Registration District No. **1000**

Registrar's No. **1401**

1. PLACE OF DEATH:

(a) County **Buchanan**
(b) City or town **St. Joseph**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **St. Joseph Hospital**
(If not in hospital or institution, write street number or location) **0**
(d) Length of stay: In hospital or institution **19 days**
(Specify whether years, months or days) **19 days**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Daviess**
(c) City or town **Altamont**
(If outside city or town limits, write "RURAL")
(d) Street No. **"** (If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country **"**

3. (a) PRINT FULL NAME **George Grant Tedrick**

3. (b) If veteran, name war **none** 3. (c) Social Security No. **none**

4. Sex **male** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **married**
6. (b) Name of husband or wife **Addie Tedrick** 6. (c) Age of husband or wife if alive **73** years
7. Birth date of deceased **October 6 1869**
(Month) (Day) (Year)

8. AGE: Years **78** Months **1** Days **15** If less than one day hr. min.

9. Birthplace **Daviess County Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Editor**

11. Industry or business **Newspaper**

MOTHER FATHER
12. Name **John H. Tedrick**
13. Birthplace **Unk. Maryland**
(City, town, or county) (State or foreign country)
14. Maiden name **Rebecca Shaffer**
15. Birthplace **Unk. Ohio**
(City, town, or county) (State or foreign country)

16. (a) Informant **Oris Tedrick**
(b) Address **Altamont, Missouri**
17. (a) removal (b) Date thereof **11-21-47**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Altamont Missouri**

18. (a) Signature of funeral director **Stoney Funeral Home**
(b) Address **St. Joseph, Missouri**
19. (a) **11-29-47** (b) **R. L. Jenkins**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov.** day **21** year **1947** hour **6** minute **PM**

21. I hereby certify that I attended the deceased from **11/21/47** to **Nov 21 1947**
that I last saw **him** alive on **Nov 21 1947**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage**
Due to **Hypertensive Heart disease**

Due to
Other conditions (Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: Of operations **GBD**
Of autopsy

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) (e) Means of injury

23. Signature **Charles Greig** (M. D. or other) **0**
Address **P. O. Box 109, St. Joseph, Mo** Date signed **11/21/47**

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

Greenberg

DEC 11 1947

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.....

Charles M. Harman

Registered Apprentice No. *450*

working under my personal supervision.

Signed.....

John Roy Stamey

Licensed Embalmer No. *2435*

P. O. Address *H. Joseph*

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.