S. No. 300
10-48

AUG 4 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 24637

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 3288

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

1. PLACE OF DEATH
a. COUNTY: Jackson
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): KansasnCity
c. LENGTH OF STAY (In this place): 35 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): General Hospital #2

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Jackson
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kansas City
d. STREET ADDRESS (If rural, give location): 1028 Tracy 3168

3. NAME OF DECEASED (Type or Print)
a. (First): Eugene
b. (Middle):
c. (Last): Redrick

4. DATE OF DEATH (Month) 7 (Day) 3 (Year) 52

5. SEX: Male 2
6. COLOR OR RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Unknown 9
8. DATE OF BIRTH: Unknown
9. AGE (In years last birthday): Unknown
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Unknown 9
12. CITIZEN OF WHAT COUNTRY?: America

13a. FATHER'S NAME: Unknown
13b. MOTHER'S MAIDEN NAME: Unknown
14. NAME OF HUSBAND OR WIFE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT'S SIGNATURE OR NAME ADDRESS: Mattie Mack, 1030 Tracy -R.C., Mo.

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Vascular Accident

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: 331 X

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-21-52, *19*___, *to* 7-3-52, *19*___, *that I last saw the deceased alive on* 7-3-52, *19*___, *and that death occurred at* 12:35 p *m., from the causes and on the date stated above.*

23a. SIGNATURE E. Frank Ellis, M.D. (Degree or title) Rumb Ellis, Mo
23b. ADDRESS: 600 E. 22nd St.
23c. DATE SIGNED: 7-3-52

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 5
24b. DATE: July 21 '52
24c. NAME OF CEMETERY OR CREMATORY: Woodlawn
24d. LOCATION (City, town, or county) (State): KansasCity, Kans.

DATE REC'D BY LOCAL REG.: 7-21-52
REGISTRAR'S SIGNATURE: Geraldine Holmes
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: C. E. Davis 1415 Truman

(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 _____, Student Embalmer No. _____, working under my personal supervision.

Student _____
Student Embalmer

Signed Landie H. Jackson

Licensed Embalmer No. 4850

P. O. Address K. C. 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.