

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

10604

State File No. _____

Registrar's No. 114

BIRTH NO. _____ REG. DIST. NO. 209 PRIMARY REG. DIST. NO. 3496

FILED MAR 20 1953

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

1. PLACE OF DEATH a. COUNTY <u>MARION</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>ILL.</u> b. COUNTY <u>ADAMS</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ANNIDAL</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>QUINCY</u> <u>8120</u>	
c. LENGTH OF STAY (In this place) <u>3 WKS.</u>		d. STREET ADDRESS (If rural, give location) <u>RR #5</u> <u>8</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1205 LEFORD ST.</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>MARGARET</u>	b. (Middle) <u>MILLER</u>	c. (Last) <u>REDDICK</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>3-13-1953</u>
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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>AUG 23, 1898</u>	9. AGE (In years last birthday) <u>54</u>	10. MONTHS <u>0</u>	11. DAYS <u>0</u>	12. HOURS <u>0</u>	13. MIN. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work considering most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>TAYLOR, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		

13a. FATHER'S NAME <u>FRED TATE</u>	13b. MOTHER'S MAIDEN NAME <u>AMANDA LEFFERT</u>	14. NAME OF HUSBAND OR WIFE <u>TOM RERICK</u>
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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>—</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Stone Reddick - Quincy, Ill</u>	18. ADDRESS <u>—</u>
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Thrombosis.</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cerebral Sclerosis</u> DUE TO (c) <u>—</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>10</u>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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 Feb 2, 1952, to March 7, 1953 that I last saw the deceased alive on 2 March, 1953, and that death occurred at 6:00 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>M. J. Jelen M.D.</u>	23b. ADDRESS <u>Harwood Mo.</u>	23c. DATE SIGNED <u>March 13, 1953</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE <u>3-16-53</u>	24c. NAME OF CEMETERY OR CREMATORY <u>WESTER CEMETERY</u>	24d. LOCATION (City, town, or county) (State) <u>MAYWOOD, MO</u>
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DATE REC'D BY LOCAL REG. <u>3/16/53</u>	REGISTRAR'S SIGNATURE <u>DK M. Lucke</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph Clark</u>	ADDRESS <u>Harwood Mo.</u>
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(Licensed Embalmer's Statement on Reverse Side)

RECEIVED MAR 18 1953
N. A. RICHMOND O. HEALTH DEPT.
DATE FILED MAR 18 1953

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 Ralph Clark

Licensed Embalmer No. 14217

P. O. Address Hospital

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.