

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-021488
State File No.

FILED JUL 15 1958

BIRTH NO. _____ REG. DIST. NO. 113 PRIMARY REG. DIST. NO. 5730 Registrar's No. 679

1. PLACE OF DEATH a. COUNTY Franklin		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Franklin	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural-Centrel		c. LENGTH OF STAY (in this place) 50 yrs	c. CITY OR TOWN Union 0360
d. FULL NAME OF HOSPITAL OR INSTITUTION		STREET ADDRESS (If rural, give location) Rural Route 2	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) Gustave	b. (Middle) Karl	c. (Last) Redhage	(Month) July	(Day) 6	(Year) 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Dec. 4, 1883	9. AGE (In years last birthday) 74	IF UNDER 1 YEAR Months 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (City and State or Foreign Country) Dittmer, Mo.		12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME August Redhage	13b. MOTHER'S MAIDEN NAME Caroline Horstman	14. NAME OF HUSBAND OR WIFE Lillie Redhage
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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) No	16. SOCIAL SECURITY NO. 494-42-5481	17. INFORMANT'S SIGNATURE OR NAME Lillie Redhage	ADDRESS Union, Mo.
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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, asthenia, 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) Pulmonary fibrosis		6 mos.
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Bronchial asthma		10 years
DUE TO (c) Chronic Bronchitis (Bacterial)		6 mos.	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 5021	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)
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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?
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22. I hereby certify that I attended the deceased from 15 May, 1958, to 6 July, 1958, that I last saw the deceased alive on 30 June, 1958, and that death occurred at 10 P. M., from the causes and on the date stated above.

23a. SIGNATURE Wm. Richardson, M.D.	(Degree or title)	23b. ADDRESS Union, Mo.	23c. DATE SIGNED 7 July 58
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE July 8-58	24c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery	24d. LOCATION (City, town, or county) (State) Lonedell, Mo.
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DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE 7-7-58	REGISTRAR'S SIGNATURE Casey Lenox	25. FUNERAL DIRECTOR'S SIGNATURE Casey-Lenox	ADDRESS St. Clair, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

JUL 8 1958

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 *K. M. Leno*.....

Licensed Embalmer No. *3601*.....

P. O. Address *St. Clair,*.....

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.