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

Do not use this space.

47 4

1. PLACE OF DEATH
County Jackson — Registration District No. 399 — File No. 4 [illegible]
Township Kaw — Primary Registration District No. 700 — Registered No. [illegible]
City K. C. (No. St Joseph Hosp St. Ward)

2. FULL NAME Mrs Nora C Richardson
(a) Residence. No. 925 Paseo St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. 8 mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: wh
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): widow

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: F. G. Richardson

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Jan 16th 1879

7. AGE: Years 48 — Months X — Days 17 — If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: at Home
(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): Mo

PARENTS
10. NAME OF FATHER: No Data
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): No Data
12. MAIDEN NAME OF MOTHER: Nellie McFall
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): No Data

14. INFORMANT: T E Garrett
(Address): No Little Rock Ark

15. FILED 2/3, 1927 M. M. Crowe Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 2/2/27 19

17. I HEREBY CERTIFY, That I attended deceased from Jan 29, 1927, to Feb 2, 1927 that I last saw her alive on Feb 2, 1927, and that death occurred, on the date stated above, at 6 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
11A
95A
Heart-Block
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY): Influenza Pneumonia
(duration) yrs. mos. 7 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) Unsetherington, M. D
2/3, 1927 (Address) 925 Sheffield

*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: Little Rock Ark — DATE OF ~~BURIAL~~ Ship: 2/3/27 19

20. UNDERTAKER: W. F. Mayberry Co — ADDRESS: City

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Dr Hellmingtan