MAR 28 1930

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

Do not use this space. 7343

1. PLACE OF DEATH
County: Saline
Township: Salem Twp
City: Salem (No. ..... St. ..... Ward)
Registration District No. 499
Primary Registration District No. 4479
File No. .....
Registered No. 12

2. FULL NAME John Lawrence Richardson

(a) Residence. No. ..... 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. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. ~~SINGLE~~, MARRIED, ~~WIDOWED~~ OR ~~DIVORCED~~ (write the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED ~~HUSBAND OF~~ (OR) WIFE OF: Ada Ann Richardson

6. DATE OF BIRTH (MONTH, DAY AND YEAR): April 16 1868

7. AGE: Years 61 | Months 10 | Days 1 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: .....

9. BIRTHPLACE (CITY OR TOWN): Shell City
(STATE OR COUNTRY): Mo

PARENTS
10. NAME OF FATHER: John Richardson
11. BIRTHPLACE OF FATHER (CITY OR TOWN): Unknown
(STATE OR COUNTRY): .....
12. MAIDEN NAME OF MOTHER: Lucinda Pesley
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): Unknown
(STATE OR COUNTRY): Kentucky Or Mo

14. INFORMANT: Mrs Ada Ann Richardson
(Address): Slater Mo

15. FILED 3 18 1930 W. M. Tuttle REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): February 17 1930

17. I HEREBY CERTIFY, That I attended deceased from February 4, 1930, to February 16, 1930, that I last saw him alive on Feb 16, 1930, and that death occurred, on the date stated above, at 3 40 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Interstitial Nephritis
131
(duration) 1 yrs. 6 mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH: at Home
DID AN OPERATION PRECEDE DEATH? No. DATE OF .....
WAS THERE AN AUTOPSY? No.
WHAT TEST CONFIRMED DIAGNOSIS? Clinic + Lab
(Signed) H. E. Lectwood, M. D.
, 19 (Address) Slater Mo

*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: Fairview City Cemetery — DATE OF BURIAL: February 19 1930
20. UNDERTAKER: Forbes & Sapp — ADDRESS: Slater Mo

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.

IMPORTANT—PLACE WITH SIGNING NURSE—THIS IS A PERMANENT RECORD