

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

Do not use this space.

8049

MAY 23 1930

1. PLACE OF DEATH

County Chariton
Township _____
City Salisbury (No. _____)

Registration District No. 175
Primary Registration District No. 1104

File No. _____
Registered No. 23
St. _____ Ward)

2. FULL NAME

Lida Richardson
(a) Residence, No. _____ St. _____ Ward _____
(Usual place of abode)

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 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 Thomas Richardson ¹⁹³⁰

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 23-1873

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<u>56</u>	<u>7</u>	<u>2</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____
(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) _____

PARENTS

10. NAME OF FATHER J. F. Lay Mo.

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) _____

12. MAIDEN NAME OF MOTHER N. Robertson Mo.

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) _____

14. INFORMANT MR. Thomas Richardson (Address) Salisbury, Mo.

15. FILED 3/25 1930 J. W. Stepien REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-25 1930

17. I HEREBY CERTIFY, That I attended deceased from 3-1, 1930, to 3-25, 1930, that I last saw her alive on 3-24, 1930, and that death occurred, on the date stated above, at 2:00 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

acute catarrhal jaundice.

CONTRIBUTORY (SECONDARY) 12-4-13 (duration) yrs. mos. 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) William W. Fellows, M. D.

3/25 1930 (Address) Salisbury, 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 Salisbury cem DATE OF BURIAL 3-27 1930

20. UNDERTAKER Winkelmyer Bros ADDRESS Salisbury

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.

