

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

40342

1. PLACE OF DEATH
 County Boonville Registration District No. 670
 Township North Creek Primary Registration District No. 5896
 City Boonville (No. 17712) St. _____ Ward _____
 2. FULL NAME Lewis Elsworth Richards
 (a) Residence No. Boonville, 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.

File No. _____
 Registered No. 1

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE W. 5. ~~SINGLE~~ MARRIED, WIDOWED OR DIVORCED (as if the wife)
Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Edith Richards
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar 2-1882
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
48 9 16
 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) Self
 (c) Name of employer None

9. BIRTHPLACE (CITY OR TOWN) Otterville
 (STATE OR COUNTRY) Mo.

10. NAME OF FATHER Jake Richard
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) unknown
 (STATE OR COUNTRY) Kentucky
 12. MAIDEN NAME OF MOTHER Anna Ward
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) unknown
 (STATE OR COUNTRY) Illinois

14. INFORMANT Bernest McLaughlin
 (Address) Marshall Mo

15. FILED 1/8 1931 Flossie Ferguson
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec. 18-1930

17. I HEREBY CERTIFY, That I attended deceased from Dec 17, 1930, to Dec 17, 1930 that I last saw him alive on Dec 17-1930 and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Valvular Heart Disease
mitral regurgitation
92
 (duration) _____ yrs. _____ mos. _____ ds.
 CONTRIBUTORY (SECONDARY) 90
 (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) H. Prosser, M. D.
 (Address) Longwood 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 Union Cemetery DATE OF BURIAL Dec 19 1930

20. UNDERTAKER Hayes Stocklen ADDRESS Polk 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.

JAN 21 1931

PARENTS

