

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

Do not use this space.

7968

File No. 64
Registered No. 333
St. _____ Ward _____

1. PLACE OF DEATH
35 County Douglas Registration District No. 283
Township Buffalo Primary Registration District No. 3408
City _____ (No. _____) _____ St. _____ Ward _____

2. FULL NAME
J. E. 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

MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mattie Richardson

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct-9-1888

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
50 5 11

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb-21 1932

17. I HEREBY CERTIFY, That I attended deceased from Feb-15, 1932, to Feb-21, 1932, that I last saw him alive on Feb-21, 1932, and that death occurred, on the date stated above, at 7:00 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pneumonia
107A (duration) _____ yrs. _____ mos. _____ ds.

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

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 _____

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH _____

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

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? (1)

PARENTS
10. NAME OF FATHER Sam Richardson
11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Alto
12. MAIDEN NAME OF MOTHER M.C.
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Alto

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) E. J. Bask, M. D.
, 19 _____ (Address) Co. Lawrence Mo.

14. INFORMANT Sam Richardson
(Address) Co. Lawrence 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.

15. FILED 3/21 1932 M. G. Moore REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Co. Lawrence Mo. DATE OF BURIAL 3-22 1932
20. UNDERTAKER H. Mitchell Co. Lawrence Mo.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very

APR 26 1932

CAUSE
DRAFT

Classified by
174

**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Hempden
Township Buffalo
City J.E. Richardson (No. _____)

Registration District No. 283
Primary Registration District No. 5402

File No. _____
Registered No. 64 St. _____ Ward _____

2. FULL NAME

(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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) M

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year) _____

11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER
13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE 19____

19. UNDERTAKER (ADDRESS)

20. FILED May 13 1932 Levin Walker Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar 21, 1932

22. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19____

I last saw him _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Pneumonia
Bleeds - Pneumonia
Date of onset _____
Other contributory causes of importance: 1070

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?

If so, specify _____ (Signed) _____, M. D.
(Address) _____

SUPPLEMENTARY

N. B. - Every item of information should be carefully supplied. It should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED

5-7965