

REC'D JUN 21 1939

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

18479

Do not use this space.

1. PLACE OF DEATH *2*
- (a) County *Wallace* Registration District No. *243*
- (b) Township *Jackson* Primary Registration District No. *5336*
- (c) City *Buffalo* (d) Street No. _____ St. _____
- (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.
2. PRINT FULL NAME *Anna Belle Richardson*
- (a) Residence, No. _____ St. (If nonresident, give city or town and State)
- (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <i>F</i>	4. COLOR OR RACE <i>W</i>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED <i>W</i> (write the word)
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <i>✓</i>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <i>March 3 - 1932</i>		
7. AGE	YEARS <i>7</i>	MONTHS <i>2</i>
	DAYS <i>4</i>	If LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.	
	9. Industry or business in which work was done, as saw mill, bank, etc.	
	10. Date deceased last worked at this occupation (month and year)	
	11. Total time (years) spent in this occupation <i>5 1/2</i>	
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Leonia Mo</i>		
FATHER	13. NAME <i>Eugene Leslie Richardson</i>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Centerville Mo</i>	
MOTHER	15. MAIDEN NAME <i>Eula Lee Terry</i>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Leonia Mo</i>	
17. INFORMANT <i>E. L. Richardson</i> (ADDRESS) <i>Buffalo Mo</i>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <i>Walnut Grove</i> DATE <i>5-9-39</i> <i>Gravestone Parkery</i>		
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <i>Edgar</i> <i>Buffalo Mo</i>		
20. FILED <i>5-10</i> 19 <i>39</i> <i>Mrs J N Shewmaker</i> Local Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *5-7-39*

22. I HEREBY CERTIFY, That, I attended deceased from *Arrived after death 5-7-39*
 I last saw h. *never saw her alive* Death is said to have occurred on the date stated above, at *99* m.
 The principal cause of death and related causes of importance were as follows:
Congenital malformation of maldevelopment of brain chid never talked or walked left side of skull face deformed

Other contributory causes of importance:
Brain tumor, probably chid had profertile vomiting

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? *no*
 If so, specify _____
 (Signed) *H. H. Plummer*, M. D.
 (Address) *Buffalo Mo*

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH SERVICES
BUREAU OF HEALTH SERVICES

RECEIVED

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District Health Officer No. 7,

District File Number 7-39-840

Date Filed 6-2-39

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by

Registered Apprentice No. _____, working under my personal supervision.

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.