

550 JUN 24 1939

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

19906  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Schuyler Registration District No. 806  
 (b) Township Marie Primary Registration District No. 6051 Registered No. \_\_\_\_\_  
 (c) City Near Independence MO (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred 2 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME MILLIE E. 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 female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Widow  
 (write the word)  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF John Richardson (deceased)  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 31 - 1858  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
80 9 24  
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. House Wife  
 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 life  
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Greensburg Missouri  
Hotland Co  
 FATHER 13. NAME James Kinmons  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana  
 MOTHER 15. MAIDEN NAME Sarah Oxford  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana  
 17. INFORMANT Wm Richardson  
 (ADDRESS) Washington MO  
 18. BURIAL, CREMATION, OR REMOVAL PLACE Martine Town DATE May 25 39  
 19. FUNERAL DIRECTOR Wm N West  
 (ADDRESS) Independence MO  
 20. FILED 5/24/39 J. T. Jones Oliver B. Jones  
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 24 1939  
 22. I HEREBY CERTIFY, That I attended deceased from May 18 1939 to May 24 1939  
 I last saw her alive on May 12 1939. Death is said to have occurred on the date stated above, at 5.9 m.  
 The principal cause of death and related causes of importance were as follows:  
apoplexy first attack about 10 year ago. Last attack May 20 - 1939  
 Date of onset \_\_\_\_\_  
 Other contributory causes of importance:  
Infermities of age. 80  
 Name of operation None Date of \_\_\_\_\_  
 What test confirmed diagnosis? Stomach Was there an autopsy? \_\_\_\_\_  
 23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? No 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) A. R. Johnson M. D.  
Greenwood MO (Address)

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.

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RECEIVED

District Health Officer No. 10

District File Number 10-39-996

Date Filed 6-8-39

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STATEMENT BY LICENSED EMBALMER

I, ....., Licensed Embalmer No.....

hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....

..... L. E. ....

No.....or by....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

**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.)**