

1939 AUG 14 1935

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

26670  
Do not use this space.

1. PLACE OF DEATH

(a) County St. Charles Registration District No. 257  
(b) Township St. Charles Primary Registration District No. 3036 Registered No. 104  
(c) City St. Charles (d) Street No. 239 Houston Av 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 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 239 Houston Av 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 Male 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 Melvin Phillip

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) October 11th, 1885

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>53</u>	<u>9</u>	<u>6</u>	

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Carpenter

9. Industry or business in which work was done, as saw mill, bank, etc. Construction

10. Date deceased last worked at this occupation (month and year) July 19, 1939 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Apopka County, Iowa

FATHER

13. NAME Irving A Richardson

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Apopka County, Iowa

MOTHER

15. MAIDEN NAME Lillian Taylor

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Apopka County, Iowa

17. INFORMANT (ADDRESS) Wilfred Richardson

18. BURIAL, CREMATION, OR REMOVAL PLACE Oak Grove Cemetery DATE July 20, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Wesleyman Bau  
St. Charles Mo

20. FILED 7/20 1939 Clarence H. Mueller  
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 17th, 1939

22. I HEREBY CERTIFY, That I attended deceased from July 14, 1939 to July 17, 1939  
I last saw him alive on July 17, 1939. Death is said to have occurred on the date stated above, at 9:45 P. m.  
The principal cause of death and related causes of importance were as follows:  
Angina Pectoris  
g.f.k.

Other contributory causes of importance:

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) T.R. Harder, M. D.  
(Address) St. Charles, Mo.

Date of onset July 14, 1939

K. 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.

**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 *Arthur J. Face*  
Licensed Embalmer No. *3144*  
P. O. Address *St. Charles*

**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.**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

26670

Do not use this space.

1. PLACE OF DEATH *St Charles*  
(a) County *St Charles* Registration District No. *75-7*  
(b) Township *St Charles* Primary Registration District No. *3036* Registered No. \_\_\_\_\_  
(c) City *St Charles* (d) Street No. \_\_\_\_\_ (If death occurred in Hospital or Institution, write its name instead of street and number) 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 *FRARA Guy 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

MEDICAL CERTIFICATE OF DEATH

3. SEX *m* 4. COLOR OR RACE *w* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write the word*) *m*
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) \_\_\_\_\_
7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
*53 9 6*
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 \_\_\_\_\_
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. FUNERAL DIRECTOR (ADDRESS) \_\_\_\_\_
20. FILED *9/14/39*, 19\_\_\_\_ *Charles B. Mosler* Local Registrar.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *9-17-1939*
22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_
- I last saw h. \_\_\_\_\_ 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: \_\_\_\_\_
- Date of onset \_\_\_\_\_
- Other contributory causes of importance: \_\_\_\_\_
- 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) *A. R. Hardin*, M. D.  
(Address) *St Charles Mo*

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 COMPLETED AS PRESCRIBED BY LAW.

S-26870

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