

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

32278
Do not use this space.

1. PLACE OF DEATH

(a) County Daviess Registration District No. 259

(b) Township _____ Primary Registration District No. 4150 Registered No. 24

(c) City Gallatin, (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 10 yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME Katie Richesson

(a) Residence, No. Gallatin, Mo. 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 (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF John Wesley Richesson

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug. 14, 1869

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
70	1	11	

OCCUPATION

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

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) Aug. 1939 11. Total time (years) spent in this occupation Life

12. BIRTHPLACE (CITY OR TOWN) Estill Co. Kentucky
(STATE OR COUNTRY)

FATHER

13. NAME James W. Vaughn

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

MOTHER

15. MAIDEN NAME Sarah Jane Smith

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

17. INFORMANT Mrs Eva Carlton
(ADDRESS) Kansas City, Missouri

18. BURIAL, CREMATION, OR REMOVAL
PLACE McCrory Cem. DATE Sept. 27, 1939

19. FUNERAL DIRECTOR (NAME) Hope Furn. & Undr. Co.
(ADDRESS) Gallatin, Mo.

20. FILED Sept. 27, 1939 N. J. Hope Local Registrar. 297 (Address) Gallatin Mo.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept. 25, 1939

22. I HEREBY CERTIFY, That I attended deceased from 8-25, 1939, to 8-25, 1939
I last saw him alive on 9-20, 1939. Death is said to have occurred on the date stated above, at 6:15 PM
The principal cause of death and related causes of importance were as follows:
Myocardial Exhaustion
Hypertensive-Cardio-
Vascular Disease
Date of onset 1939
1930

Other contributory causes of importance: a.s.k.

Name of operation None Date of _____
What test confirmed diagnosis? None Was there an autopsy? No

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) Edmund H. Hays, M. D.
(Address) Gallatin Mo.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD
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.

I X 16605

Dist. No. 1039-1347
Date Filed Jul 17 1939

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.....
.....
working under my personal supervision.

Registered Apprentice No.....
Signed *L. O. Dickerson*
Licensed Embalmer No. *3302*
P. O. Address *Gallatin, Miss.*

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.