

Primary Registration District No. 453E

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Wash 2
(b) City or town WATSON
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ years, months or days

3. (a) PRINT FULL NAME Stillborn Richards 263

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race W 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Oct 12 39
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace Pobon mo
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name Harrison Richards 0

13. Birthplace Illusion mo
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth May Sample

15. Birthplace Franklin mo
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Harrison Richards

(b) Address Pobon mo

17. (a) _____ (b) Date thereof Oct 12, 39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Furnace Creek

18. (a) Signature of funeral director none

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County Wash 1
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 12
year 1939 hour 3 AM minute _____ M.

21. I hereby certify that I attended the deceased from Oct 12, 1939, to _____, 1939; that I last saw _____ alive on _____, 1939; and that death occurred on the date and hour stated above.

Immediate cause of death
Asphyxia from breech presentation.
Due to Rubbed off hands arms. Appearance of garden mole
Other conditions: _____
(Include pregnancy within 3 months of death)

Duration _____

Major findings:
Of operations _____
Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) _____
(a) Means of injury _____
23. Signature [Signature] (M. D. or other) _____
Address Pobon mo Date signed _____

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.

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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

33793

Do not use this space.

1. PLACE OF DEATH
 (a) County Washington Registration District No. 887
 (b) Township Patton Primary Registration District No. 4538 Registered No.
 (c) City Patton (d) Street No.
 (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 Stillborn - Richards
 (a) Residence, No. St. (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)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct. 12-39

7. AGE YEARS MONTHS DAYS 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

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Patton no

FATHER

13. NAME Harrison Richards
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Sullivan no

MOTHER

15. MAIDEN NAME Elaine no
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Franklin no

17. INFORMANT (ADDRESS) Harrison Richards
Patton no

18. BURIAL, CREMATION, OR REMOVAL
 PLACE Interment DATE Oct 13 1939

19. FUNERAL DIRECTOR (ADDRESS) none

20. FILED Nov 14 1939 G.F. Chesney
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 12 1939

22. I HEREBY CERTIFY, That I attended deceased from Oct 12 1939, to Oct 12 1939
 I last saw him alive on Oct 12 1939, 19... Death is said to have occurred on the date stated above, at 3 A.M.
 The principal cause of death and related causes of importance were as follows:
Asphyxia from cerebral protrusion
due to trauma & arm compression of border of chest
whole
 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 G.F. Presnell, M. D.
 (Address) Patton

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
 CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

