

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.

Registration District No. 775

Primary Registration District No. 6020

1. PLACE OF DEATH:

(a) County St. Francois

(b) City or town R-1 Bonne Terre Mo
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Francois

(c) City or town Bonne Terre
(If outside city or town limits, write "RURAL")

(d) Street No. Route 1
(If rural, give location)

(e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME WM. WALTER RICHARDSON

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Gda Richardson

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

7. Birth date of deceased April 9 1865
(Month) (Day) (Year)

8. AGE: Years 74 Months 7 Days 15 If less than one day _____ hr. _____ min.

9. Birthplace St. Francois Co Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business _____

MOTHER FATHER { 12. Name Clinton S. Richardson

13. Birthplace St. Francois Co Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Clara De Bruin

15. Birthplace St. Francois Co Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs Walter Richardson

(b) Address RFD-1 Bonne Terre Missouri

17. (a) Burial (b) Date thereof Nov. 27, 1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Aylshury Chapel

18. (a) Signature of funeral director Bentham Ind Co

(b) Address 313 Bentham St Bonne Terre Mo

19. (a) Nov. 27, 1939 (b) N. W. Hopkins
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 24
year 1939 hour 9 minute 30 P. M.

21. I hereby certify that I attended the deceased from Nov - 5 - 1939 to Nov - 24 - 1939; that I last saw him alive on Nov - 20 - 1939 and that death occurred on the date and hour stated above.

Immediate cause of death cerebral hemorrhage Duration 3 mths

Due to chronic nephritis with hypertension 6 yrs

Other conditions (include pregnancy within 3 months of death) 121

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) (e) Means of injury _____

23. Signature R. L. Evans (M. D. or other) _____
Address Bonnetere Mo Date signed 11-27-39

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.....

C. J. Claywell

Licensed Embalmer No.....

3706

P. O. Address.....

Bayne Street Mo

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.