

FILED MAR 11 1940

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

5362

Do not use this space.

1. PLACE OF DEATH

(a) County JACKSON Registration District No. 399
 (b) Township Kan Primary Registration District No. 1002 Registered No. 587
 (c) City KANSAS CITY (d) Street No. 3449 Holmes 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

WILLIAM T. RICHARDSON
 (a) Residence, No. 3449 HOLMES- 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 M **4. COLOR OR RACE** W **5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)** MARRIED

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov - 4 - 1861

7. AGE YEARS 78 MONTHS 3 DAYS 3 If LESS than 1 day, hrs. or min.

OCCUPATION **8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.** RETIRED

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) 1932 **11. Total time (years) spent in this occupation**

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) CENTERVILLE / IOWA

FATHER **13. NAME** JAMES RICHARDSON

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) TENN-

MOTHER **15. MAIDEN NAME** AMELIA BOOTH

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) IOWA

17. INFORMANT Anice Richardson
 (ADDRESS) 3449 Holmes, St.

18. BURIAL, CREMATION, OR REMOVAL
 PLACE GREENLAWN DATE 2-9-40

19. FUNERAL DIRECTOR (NAME) (ADDRESS) BOOTH'S
RICH Hill Mo

20. FILED Feb. 7, 1940 M. M. Erwin
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) FEB - 7 - 1940

22. I HEREBY CERTIFY, That I attended deceased from July 1, 1938, to Feb 7, 1940
 first saw him alive on Feb. 7, 1940 Death is said to have occurred on the date stated above, at 4:15 P.M.
 The principal cause of death and related causes of importance were as follows:
Bronchopneumonia Date of onset Jan 15, 1940

Other contributory causes of importance:
arteriosclerosis 1935
and left hemiplegia

Name of operation none Date of _____
 What test confirmed diagnosis? Clinical 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 John H. Caldwell, M. D.
 (Signed) John H. Caldwell (Address) Kansas City, Mo.

1072

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.....

John G. Underwood

Licensed Embalmer No. *3585*

P. O. Address *Butler, Pa.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. *53627*

Registration District No.

Primary Registration District No.

Registrar's No. *587*

1. PLACE OF DEATH:

(a) County *Jackson*
(b) City or town *K.C.*
(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 *William J. Richardson*

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

4. Sex..... 5. Color or race..... 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. (Month) (Day) (Year)

8. AGE: Years Months Days If less than one year
79 *3* *3* hr. min.

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

10. Usual occupation.....

11. Industry or business.....

12. Name.....

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

14. Maiden name..... (City, town, or county) (State or foreign country)

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

16. (a) Informant.....

(b) Address.....

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

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address *277/40*

19. (a) (Date received local registrar) (b) *M. M. Browne* (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....

(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 *Feb.* Day *7* - day *40*
year..... hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....;

that I last saw him..... alive on....., 19....., and that death occurred on the date and hour stated above.

Immediate cause of death *Broncho Pneumonia*

Due to..... *§ 24'*

Due to.....

Other conditions *Arteriosclerosis*
(Include pregnancy within 3 months of death)

Major findings: *th. hemiplegia from cerebral hemorrhage*

Of operations.....

Of autopsy.....

Duration

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?

(Specify type of place)

While at work?..... (e) Means of injury.....

23. Signature *J. K. Caldwell* (M. D. or other) *MD*

Address *K.C. Mo.* Date signed *4/1/40*

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

✓

S-5362

04/18