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

21146

1. PLACE OF DEATH
County: Bates — Registration District No. — File No.
Township: — Primary Registration District No. — Registered No.
City: — (No. — St. — Ward)

2. FULL NAME: Susan E. Richardson
(a) Residence. No. Worland Mo St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 20 yrs. ✓ mos. ✓ ds. How long in U.S., if of foreign birth? yrs. mos. ds.

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 Richards

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Dec-9-1856

7. AGE: 83 Years — Months: 5 — Days: 23 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Home Wife
(b) General nature of industry, business, or establishment in which employed (or employer): General
(c) Name of employer: —

9. BIRTHPLACE (CITY OR TOWN): Vincenz — 1
(STATE OR COUNTRY): Indian

PARENTS
10. NAME OF FATHER: Albert Seely
11. BIRTHPLACE OF FATHER (CITY OR TOWN): Unknown
(STATE OR COUNTRY): Unknown
12. MAIDEN NAME OF MOTHER: Catherine Seeley
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): Unknown
(STATE OR COUNTRY): Unknown

14. INFORMANT: Elmer Whitted
(Address): Rural Greeley Colorado

15. FILED 6/15 1940 Mrs. C. Wiens REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): June-2 1940

17. I HEREBY CERTIFY, That I attended deceased from May 25 ~~June 2~~, 1940 to June 2 1940 that I last saw her alive on June 2, 1940 and that death occurred, on the date stated above, at 1:15 PM.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Influenza - 5 wks ago - with enteritis and pharangitis
Hypostatic Pneumonia 11 A
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY): Chronic nephritis ? (duration) ? yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED: at place of death
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? no DATE OF
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) Fred E. Dunlap M.D.
6-3, 1940 (Address) Pleasanton, Kansas

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Mount Olive — DATE OF BURIAL: June 5 1940

20. UNDERTAKER: Charles Son — ADDRESS: Pleasanton Kansas

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

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No....., ...St. .....Ward)

2. FULL NAME .....

(a) Residence. No..... St., ...Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	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)

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

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY)

14.
INFORMANT .....
(Address)

15.
FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

17.
I HEREBY CERTIFY, That I attended deceased from .....
....., 19....., to ....., 19.....
that I last saw h..... alive ....., 19....., and that death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

.....(duration).....yrs. .....mos. .....ds.

CONTRIBUTORY.....
(SECONDARY)

.....(duration).....yrs. .....mos. .....ds.

RECEIVED
District Health Officer No. 7
District File Number 7-40-281
Date Filed 7-9-40

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS