

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

2. CERTIFICATE OF DEATH

22100

Do not use this space.

1. PLACE OF DEATH

(a) County Laclede Registration District No. 449
 (b) Township Spring Hollow Primary Registration District No. 56-13
 (c) City _____ (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 yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Edmund Edith Richardson
 (a) Residence, No. Phillipsburg 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 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 Stella Maye Richardson

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 31-1872

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<u>68</u>	<u>4</u>	<u>14</u>	

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
 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) mo. 6

FATHER 13. NAME Non Richardson 9

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown 0

MOTHER 15. MAIDEN NAME

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

17. INFORMANT (ADDRESS) Stella Maye Richardson
Phillipsburg mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Newhope Cem. DATE 5-16 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) L. B. Jones
Buffalo mo

20. FILED 5-18 1940 J. M. Comb
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-15, 1940

22. I HEREBY CERTIFY, That I attended deceased from 5-13, 1940 to 5-15, 1940
 I last saw him alive on 5-15, 1940. Death is said to have occurred on the date stated above, at 5:30 a.m.
 The principal cause of death and related causes of importance were as follows:

dilation of right ventricle of heart

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? No
 If so, specify _____
 (Signed) J. W. Henderson, M. D.
 (Address) Conway mo

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.

RECEIVED
District Health Officer No. 7,
District File Number 7-40-96A
Date Filed 7-1-40

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.