

Registration District No. 399

Primary Registration District No. 1002

Registrar's No.

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution St. Joseph's Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 4 Days  
In this community 27 Years  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3839 East 67th Street Terrace  
(If rural, give location)  
(e) If foreign born, how long in U. S. A? --- years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 29 year 1940 minute 5:10 P.M.  
21. I hereby certify that I attended the deceased from 5-1-40 to 7-29-40  
that he was born alive on 5-1-19 and that death occurred on the date and hour stated above.  
Immediate cause of death: Subarachnoid & intracerebral hemorrhage  
Fracture of the skull  
Automobile Traumatism

Duration

PHYSICIAN

Major findings:

Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
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) Accident  
(b) Date of occurrence 7-26-40  
(c) Where did injury occur? Jackson, Co  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

23. Signature R. L. Moore (M. D. or other)  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

3. (a) PRINT FULL NAME FRANK WILLIAM RICHARDSON

3. (b) If veteran, name war None 3. (c) Social Security No. 495-05-2689

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mrs. Verna Richardson 6. (c) Age of husband or wife if alive 26 years

7. Birth date of deceased November 14 1912  
(Month) (Day) (Year)

8. AGE: Years 27 Months 8 Days 15 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Truck Driver

11. Industry or business Own Truck

12. Name Charles J. Richardson

18. Birthplace Kansas City Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name Elsie Rao

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

16. (a) Informant Chas Richardson

(b) Address 3839 E 67 Terrace

17. (a) Burial (b) Date thereof July 31 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill Cemetery

18. (a) Signature of funeral director R. H. Newcomer's son

(b) Address 1401 Brush Creek Blvd.  
July 30, 1940

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

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

217 MW  
95

**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

*H. C. Newcomer Jr.*

Licensed Embalmer No. *4045*

P. O. Address *K. C. 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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. ....

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. ....

Primary Registration District No. ....

Registrar's No. **3044**

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

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City  
(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.....  
In this community..... (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME Frnk William 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 day  
..... hr. .... min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 12. Name.....

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

14. Maiden name.....

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

16. (a) Informant.....

(b) Address.....

17. (a)..... (b) Date thereof..... (Month) (Day) (Year)

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

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

(b) Address.....

19. (a) July 30, 1940 (b) M. M. Browne  
(Date received local registrar) (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 July day 29th  
year 1940 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19..... to..... 19.....  
that I last saw h..... alive on..... 19.....  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Subarachnoid & Subdural cerebral hemorrhage.

Due to Fracture of Skull

Due to Automobile traumatism

Other conditions..... (Include pregnancy within 3 months of death)

Major findings:  
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) Accident

(b) Date of occurrence Jackson County, Mo.

(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?  
Collision accident.

While at work?..... (Specify type of place) (e) Means of injury.....

23. Signature..... (M. D. or other).....

Address..... Date signed.....

S-24434