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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 12 1940

Registration District No. 399

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

State File No. 34425

Registrar's No. 3941

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: Swope Park (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether

In this community 30 years. 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. 3449 Holmes (If rural, give location)

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

3. (a) PRINT FULL NAME Wm T. RICHARDSON

3. (b) If veteran, name war World War

3. (c) Social Security No. no

4. Sex M

5. Color or race W

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

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

6. (c) Age of husband or wife if alive 36 years

7. Birth date of deceased July (Month) 25 (Day) 1896 (Year)

8. AGE:

Years	Months	Days	If less than one day
44	2	18	hr. min

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

10. Usual occupation Machinist

11. Industry or business Machinist H.C. Water Dept

FATHER
12. Name Wm T Richardson
13. Birthplace (City, town, or county) Iowa (State or foreign country)

MOTHER
14. Maiden name Anna Shipley
15. Birthplace (City, town, or county) Indiana (State or foreign country)

16. (a) Informant Mrs Jessie Richardson

(b) Address 3449 Holmes.

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

(c) Place: burial or cremation Butler Mo.

18. (a) Signature of funeral director Booth Funeral Home

(b) Address Butler Mo.

19. (a) 10-14-40 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month day 10-13-40

year hour minute 1:30 A.M.

21. I hereby certify that I attended the deceased from 1:30 A.M. 19 , to , 19 ;

that I last saw alive on , 19 ;

and that death occurred on the date and hour stated above.

Immediate cause of death Carbon monoxide poisoning

Due to

Due to

Other conditions (Include pregnancy within 3 months of death) 164

Major findings:
Of operations

Of autopsy Yes

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) Suicide

(b) Date of occurrence 10-13-40

(c) Where did injury occur? K. C. (City or town) (County) Mo (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 [illegible] (M. D. or other)

Address K. C. Mo Date signed

(Licensed Embalmer's Statement on Reverse Side)

FEB 5 1945

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.