

Registration District No. 477

Primary Registration District No. 4291

Registrar's No. 54

1. PLACE OF DEATH:

(a) County Lewis
(b) City or town Monticello, Mo
(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 14 days
In this community 14 days
years, months or days

3. (a) PRINT FULL NAME JESSIE MARIE RICHARDSON

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

4. Sex FEMALE 5. Color or race BLACK 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 Sept 30, 1940
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days 14 If less than one day hr _____ min _____

9. Birthplace Dickerson Twp, Lewis Co
(City, town, or county) (State or foreign country)

10. Usual occupation Infant, Baby

11. Industry or business _____

MOTHER FATHER { 12. Name Walter Elmy Richardson

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

14. Maiden name Cutahmay Tate

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

16. (a) Informant's own signature Walter Elmy Tate

(b) Address Monticello, Mo

17. (a) Burial (b) Date thereof Oct 14, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Monticello, Mo

18. (a) Signature of funeral director JAMES A. CATES

(b) Address Highway 1, Mo.

19. (a) Oct 16, 1940 (b) P. W. Jennings, Mo
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lewis
(c) City or town Monticello, Mo
(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 Oct. day 13th
year 1940 hour 10 P.M. minute _____ M.

21. I hereby certify that I attended the deceased from Oct 13, 1940, to Oct 13, 1940;
that I last saw her alive on Oct 13, 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia
Duration 9 days

Due to congenital weakness
weighing 3 lbs at birth

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

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

23. Signature Dr. Earl Porter (M.D. or other) D.O.

Address Canon Mo. Date signed 10/14/40

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should sit

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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 the above constitutes grounds for revocation of license.)

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

2B
21-40
X22659

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 39098

Registration District No. 477

Primary Registration District No. 4291

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Lewis
(b) City or town Montevallo
(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 _____ (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Jessie Marie Richardson

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

4. Sex 7 5. Color or race B 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 _____ 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) _____ (b) _____ (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 10 day 13 year 1940 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 Pneumonia
Bronchial

Due to congenital weakness
weighing three lbs
Due to at birth

Other conditions none
(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) _____

(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? _____

While at work? (Specify type of place) (a) Means of injury _____

23. Signature Earl Porter (M. D. or other) D. O.

Address Carters Date signed 1-30-41

SUPPLEMENTARY

S-39098 1940