

No. 2  
-13-40  
-17-39  
X22159

FEB 17 1941

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

Duplicate of 3558-41  
3559  
State File No. \_\_\_\_\_  
Registrar's No. \_\_\_\_\_

Registration District No. 605 Primary Registration District No. 4559

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

1. PLACE OF DEATH:  
(a) County New Madrid  
(b) City or town Tallipossa (road)  
(c) Name of hospital or institution: Thomas H. King  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community \_\_\_\_\_ years, months or days

3. (a) PRINT FULL NAME Carl Eugene Richardson  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced 50  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Mar 27 1940  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
0 9 6 hr. min

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

10. Usual occupation Paul

11. Industry or business \_\_\_\_\_

12. Name W.M. Richardson

13. Birthplace Ark 1  
(City, town, or county) (State or foreign country)

14. Maiden name Lacy Cole

15. Birthplace Ark 1  
(City, town, or county) (State or foreign country)

16. (a) Informant W.M. Richardson

(b) Address Tallipossa

17. (a) maled m (b) Date thereof Jan 3 1941  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation maled mo

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_

19. (a) 1-3-41 (b) Do. G. W. W. W. W.  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo (b) County New Madrid  
(c) City or town Tallipossa 72  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location) 0  
(e) If foreign born, how long in U. S. A.? 0 years

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Jan day 2  
year 1941 hour 4 minute 20 P. M.

21. I hereby certify that I attended the deceased from Dec 29, 1940, to Jan 2, 1941;  
that I last saw him alive on Jan 1, 1941;  
and that death occurred on the date and hour stated above.

Immediate cause of death Influenza

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

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) \_\_\_\_\_

(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? \_\_\_\_\_

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

23. Signature H. W. Davis (M. D. or other) 2  
Address maled mo Date signed 1/2/41

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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 with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**