

FILED OCT 16 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 32753

Registration District No. 837

Primary Registration District No. 4508

Registrar's No.

1. PLACE OF DEATH:

(a) County Stoddard
 (b) City or town Bloomfield
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: None
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether
 years, months or days) _____
 In this community Years

3. (a) PRINT FULL NAME DORA D. RICHARDSON3. (b) If veteran, name war --- 3. (c) Social Security No. None4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow6. (b) Name of husband or wife J. H. Richardson 6. (c) Age of husband or wife if alive Deceased years7. Birth date of deceased Oct. 21, 1861
(Month) (Day) (Year)8. AGE: Years 79 Months 10 Days 5 If less than one day
hr. _____ min. _____9. Birthplace Bloomfield, Mo.
(City, town, or county) (State or foreign country)10. Usual occupation Housewife

11. Industry or business _____

12. Name Wm. Miller13. Birthplace --- Mo.
(City, town, or county) (State or foreign country)14. Maiden name Not known15. Birthplace Not known 9
(City, town, or county) (State or foreign country)16. (a) Informant S. A. Richardson(b) Address Bloomfield, Mo.17. (a) Burial (b) Date thereof Aug. 27, 41
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Bloomfield, Mo.18. (a) Signature of funeral director Chiles Und. Co.(b) Address Bloomfield, Missouri19. (a) Sept. 17, 41 (b) Joseph Lush
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County Stoddard
 (c) City or town Bloomfield
 (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 Aug. 26th
year 1941 hour 5:45 minute A. M.21. I hereby certify that I attended the deceased from August 18, 1941
_____, 19____, to August 26, 1941;
that I last saw him alive on August 25, 1941;
and that death occurred on the date and hour stated above.Immediate cause of death Death - enteric - cause undetermined
public malignancy

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)Major findings: _____
Of operations _____

Of autopsy _____

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) (e) Means of injury 023. Signature Joseph Lederman (M. D. or other) M.D.
Address Bloomfield, Missouri Date signed 9-2-41

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

RECEIVED

District Health Office No. 2,

District File Number 1041-1427

Date Filed _____

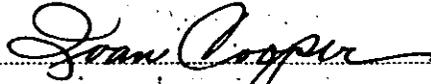
STATEMENT BY LICENSED EMBALMER

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. 4119

P. O. Address... Bloomfield, 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, fact should be so stated above.

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Primary Registration District No. 4508

1. PLACE OF DEATH: Stoddard
 (a) County Stoddard
 (b) City or town Bloomfield
 (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 _____
 years, months or days

3. (a) PRINT FULL NAME Dora W. Richardson
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced W
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Oct 21 1861
 (Month) (Day) (Year)

8. AGE: Years 79 Months 10 Days _____ If less than one day _____ 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 _____ (City, town, or county) (State or foreign country)
 { 15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____
 (Burial, cremation, or removal) (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) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month _____ Year 1941 hour _____ minute _____ M.
 21. I hereby certify that I attended the deceased from _____
 that I last saw him _____ alive on _____, 19____
 and that death occurred on the date and hour stated above.

Immediate cause of death acute enteritis
maligned probably
from seat - fatty stomach
 Due to _____
 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?
 _____ (Specify type of place)
 While at work? _____ (e) Means of injury _____

23. Signature _____ (M. D. or other) _____
 Address _____ Date signed _____

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

SUPPLEMENTARY

Bloomfield

