

FILED DEC 11 1941

Registration District No. 668Primary Registration District No. 5-889

Registrar's No.

1. PLACE OF DEATH:

(a) County..... Pettis
 (b) City or town..... Rural Harrison Twp
 (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..... 22 years (Specify whether
 years, months or days)

3. (a) PRINT FULL NAME May E. Stothard Richey,

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, Married6. (b) Name of husband or wife..... Willard Richey 6. (c) Age of husband or wife if alive..... 60 years7. Birth date of deceased..... -Oct 10 1883
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
58 1 8 hr. min.9. Birthplace Cook Co. Neb. (City, town, or county) (State or foreign country)10. Usual occupation House Wife

11. Industry or business.....

12. Name W.N. Stothard13. Birthplace London Eng. (City, town, or county) (State or foreign country)14. Maiden name Amelia Westerdale15. Birthplace Ohio. (City, town, or county) (State or foreign country)16. (a) Informant Willard Richey(b) Address La Monte Mo. R.F.D.17. (a) Dresden Mo. (b) Date thereof Nov 21-41
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Dresden Cemetery18. (a) Signature of funeral director B.F. Parker(b) Address La Monte Mo.19. (a) 11-19-41 (b) (Registrar's signature)
(Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... Mo. (b) County..... Pettis
 (c) City or town..... Rural
 (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 11-18-41
year..... hour 9-30 P.M. Minute..... M.21. I hereby certify that I attended the deceased from Nov 15 1939
to Nov 18th, 1941,
that I last saw her alive on Nov 18th, 1941,
and that death occurred on the date and hour stated above.Immediate cause of death..... Chronic Myocarditis. Duration ?Due to Old Toxic Gout - Operated
over 2 years ago -Due to.....
Other conditions Arterial Fibulation
(Include pregnancy within 3 months of death)Major findings: None. 93d PHYSICIANOf operations.....
Of autopsy..... None. 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)..... no

(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.....

23. Signature John B. Carlisle M.D. (M. D. or other)Address 314 A Ohio Street Date signed 11-20-411122 (Licensed Embalmer's Statement on Reverse Side) Judalea Mo

RECEIVED

District Health Officer No. 8;

District File Number.....

Date Filed 12-8-41

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 P. J. Cannon

Licensed Embalmer No. 1592

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 39069

Registration District No. 668

Primary Registration District No. 5889

Registrar's No.

1. PLACE OF DEATH:

- (a) County Pettis
- (b) City or town Bural
(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)

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.....

3. (a) PRINT FULL NAME

May C Richey

- 3. (b) If veteran, name was.....
- 3. (c) Social Security No.....

- 4. Sex F 5. Color of race W 6. (a) Single, widowed, married, divorced m
- 6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years
- 7. Birth date of deceased Oct. 10 1880
(Month) (Day) (Year)

- | | | | | |
|---------|--------------------|--------------------|------------------|----------------------------------|
| 8. AGE: | Years
<u>58</u> | Months
<u>1</u> | Days
<u>1</u> | If less than one day
hr. min. |
|---------|--------------------|--------------------|------------------|----------------------------------|

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

10. Usual occupation.....

11. Industry of 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) (Burial, cremation, or removal)..... (b) Date thereof.....
(Month) (Day) (Year)
- (c) Place: burial or cremation.....

- 18. (a) Signature of funeral director.....
- (b) Address.....
- 19. (a) 11-19-41 (b) B F Parlane
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

- 20. DATE OF DEATH: Month 11 day 8
year 1941 hour..... minute..... M.
- 21. I hereby certify that I attended the deceased from..... 19.....
that I last saw him..... alive on..... 19.....
and that death occurred on the date and hour stated above.
Immediate cause of death.....

Duration

- 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

S-39069