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4-13-40  
5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
JAN 24 1942

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

40790

State File No. \_\_\_\_\_

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 4465

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 K.C. General Hospital No. 1  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 days  
(Specify whether In this community years, months or days) 30 yrs 0

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 048

(c) City or town Kansas City  
(If outside city or town limits, write "RURAL") 3

(d) Street No. 1209 E. 31st St.  
(If rural, give location) 8

(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years. 0

3. (a) PRINT FULL NAME Frank Richards

3. (b) If veteran, name war no

3. (c) Social Security No. 493-12-6905

4. Sex Male 0 5. Color or race White

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

6. (b) Name of husband or wife Amanda

6. (c) Age of husband or wife if alive 67 years

7. Birth date of deceased: Jan 20 1860  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>81</u>	<u>10</u>	<u>9</u>	hr. _____ min.

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

10. Usual occupation Tool shop man

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

MOTHER FATHER

12. Name William Richards

13. Birthplace No Record  
(City, town, or county) (State or foreign country)

14. Maiden name Samantha Clampatt

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

16. (a) Informant Mrs Amanda Richards

(b) Address 1209 East 31 St.

17. (a) Burial (b) Date thereof Dec. 2 1941  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Floral Hill Cem.

18. (a) Signature of funeral director Mrs C.L. Forster

(b) Address 918 Brooklyn

19. (a) Dec 2 1941 (b) M M Crowe  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 29th  
year 1941 hour 11 minutes 48 P. M.

21. I hereby certify that I attended the deceased from 11-23-41, 19\_\_\_\_, to 11-29-41, 19\_\_\_\_;  
that I last saw h. im alive on 11-29-41, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Cerebral hemorrhage; intertrochanteric fracture of rt. femur

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

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

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

PHYSICIAN \_\_\_\_\_

Major findings: \_\_\_\_\_  
Of 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) Car 123

(b) Date of occurrence 11/29-41 mo

(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?  
Home

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

(e) Means of injury Fall

23. Signature Drury R. Thorne (M. D. or other) \_\_\_\_\_  
Address Med. Dir. K.C. Gen. Hospital Date signed 12-1-41

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

18  
3  
8

