

**JULY MAR 9 1942**  
Registration District No. \_\_\_\_\_

Primary Registration District No. 1002

State File No. \_\_\_\_\_  
Registrar's No. 764

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  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 11 Days  
In this community 40 Years  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2824 Monroe Avenue  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? -- years

3. (a) PRINT FULL NAME MARGARET RICHARDSON  
3. (b) If veteran, name war No  
3. (c) Social Security No. None

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month \_\_\_\_\_ day 2-22-42  
year \_\_\_\_\_ hour \_\_\_\_\_ minute 45 P. M.

4. Sex Female 5. Color or race White  
6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife J. A. Richardson  
6. (c) Age of husband or wife if alive -- years  
7. Birth date of deceased: July 3 1866  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and \_\_\_\_\_ occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

8. AGE: Years Months Days If less than one day  
75 7 19 hr. \_\_\_\_\_ min.

Intestinal and subarachnoid central hemorrhage  
Due to \_\_\_\_\_  
Due to falling by fall  
Other conditions 18 1/2  
(Include pregnancy within 3 months of death)

9. Birthplace Dallas Co. Iowa  
(City, town, or county) (State or foreign country)  
10. Usual occupation At Home  
11. Industry or business --

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy Yes  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

MOTHER FATHER  
12. Name James Townsend  
13. Birthplace Unknown  
(City, town, or county) (State or foreign country)  
14. Maiden name Mary Topping  
15. Birthplace Ohio  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs R. E. Hoover  
(b) Address 2824 Monroe  
17. (a) Burial (b) Date thereof Feb. 24, 1942  
(Burial, cremation, or removal) (Month) (Day) (Year)

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) Accident  
(b) Date of occurrence 2-12-42  
(c) Where did injury occur? K.C. Mo.  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
fall down stairs  
(Specify type of place) (e) Means of injury \_\_\_\_\_

(c) Place: burial or cremation Forest Hill Cemetery  
18. (a) Signature of funeral director O. H. Pedersen's Sons  
(b) Address 1401 Brush Creek Blvd.  
19. (a) 2/24/42 (b) M. M. Crowe  
(Date received local registrar) (Registrar's signature)

23. Signature M. M. Crowe (M. D. or other) \_\_\_\_\_  
Address K.C. Mo. Date signed \_\_\_\_\_

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

**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 Emile M. Calhoun

Licensed Embalmer No. 3506

P. O. Address K. E. M.

**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.**