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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

9840

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

Registrar's No. 1455

FILED APR 25 1942  
Registration District No. 279

Primary Registration District No. 1002

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City, Missouri  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
Children's Mercy Hospital  
(If not in hospital or institution write street number or location)

(d) Length of stay: In hospital or institution 22 Days  
(Specify whether)

In this community 22 days  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 068

(c) City or town Fortuna, Missouri 0  
(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 USA 1

3. (a) PRINT FULL NAME ALFRED WAYNE RICHARDSON

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. none

4. Sex M 5. Color or race W

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

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased: 2 / 4 / 1942  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
		<u>3</u>	<u>8</u>	hr. _____ min. _____

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

10. Usual occupation None

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

MOTHER FATHER { 12. Name R R Richardson

13. Birthplace Morgan County, MO  
(City, town, or county) (State or foreign country)

14. Maiden name Lillian A. Collier

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

16. (a) Informant Father

(b) Address Fortuna

17. (a) Buried (b) Date thereof 4 12 42  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Springville

18. (a) Signature of funeral director W. H. Kichell

(b) Address Fortuna, MO

19. (a) Apr 12 1942 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 12<sup>th</sup>  
year 1942 hour 4<sup>20</sup> minute \_\_\_\_\_ P.M.

21. I hereby certify that I attended the deceased from March 21 1942 to April 12<sup>th</sup> 1942  
that I last saw him alive on 4-11-42 10:45 am 1942  
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia Duration

Due to Prematurity, Infantile Tetany

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

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

159

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? \_\_\_\_\_

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

(e) Means of injury \_\_\_\_\_

23. Signature H. M. Selby / Conell (M. D. or other) 0

Address Prof. Bldg. Date signed 4-12-42

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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.**

# MISSOURI STATE BOARD OF HEALTH STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. ....

Registration District No. ....

Primary Registration District No. ....

Registrar's No.: 1455

### 1. PLACE OF DEATH:

(a) County.....  
 (b) City or town.....  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Mercy Hospital  
(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 Alfred Wayne Richardson

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

4. Sex..... 5. Color or race..... 6. (a) Single, widowed, married, divorced.....

6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... years

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
		3	8	hr. 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.....  
 { 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) 6/10/42 (Date received from registrar) (b) M. M. Grove (Registrar's signature)

### 2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....  
 (c) City or town Fortuna  
(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 April day 12th year 1942 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19..... to..... 19.....; that I last saw h..... alive on..... and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia Bronch

Due to Prematurity, Infantile Tetany

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

23. Signature..... M. M. Grove (M. D. or other) Address..... 1623 Prof Bldg Date signed.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

9840