

FILED APR 14 1943

State File No. _____

Registration District No. 315

Primary Registration District No. 6067

Registrar's No. _____

1. PLACE OF DEATH:

(a) County St. Clair
 (b) City or town Tiffin
(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 years, months or days) 18 months

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Clair
 (c) City or town Tiffin
(If outside city or town limits, write "RURAL")
 (d) Street No. _____
(If rural, give location)
 (e) Citizen of foreign country? NO (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME James H. Richardson

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

4. Sex Male 5. Color or race White 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 11 4 1864
(Month) (Day) (Year)

8. AGE: Years 78 Months 4 Days 8 If less than one day _____ hr. _____ min.

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

10. Usual occupation Fireman

11. Industry or business _____

12. Name Hugh Richardson

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

14. Maiden name Elizabeth Shepard

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

16. (a) Informant Charley Richardson

(b) Address Tiffin Missouri

17. (a) Burial (b) Date thereof 3-13-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Union Point

18. (a) Signature of funeral director Osceola Funeral Home

(b) Address Osceola Missouri

19. (a) 2-13-43 (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 12
 year 1943 hour 3 minute A. M.

21. I hereby certify that I attended the deceased from Mar. 11 1943 to Mar. 11 1943
 that I last saw him alive on Mar. 11 1943
 and that death occurred on the date and hour stated above.

Immediate cause of death myocarditis
chronic

Due to Senility

Due to Infection as only saw him a few hrs before death

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
 Of operations _____

Of autopsy no

Duration

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) no
 (b) Date of occurrence now
 (c) Where did injury occur? now
(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 now

23. Signature J. W. Richardson (M. D. or other)
 Address Tiffin Mo Date signed 3-13-43

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

RECEIVED

District Health Officer No. 7,

District File Number 3-43-46

Date Filed 4-6-43

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

Paul Frestone

Licensed Embalmer No.

3990

P. O. Address

Oscola 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 11277

Registration District No. 215

Primary Registration District No. 6067

Registrar's No. _____

1. PLACE OF DEATH:

- (a) County St Clair
- (b) City or town Jeffers
(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 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

James H. Richardson

3. (b) If veteran, name war

3. (c) Social Security No.

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

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

- 7. Birth date of deceased Nov. 4 1869
(Month) (Day) (Year)

- | 8. AGE: | Years | Months | Days | If less than one day |
|---------|-----------|----------|------|----------------------|
| | <u>78</u> | <u>4</u> | | <u>0</u> min. |

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

10. Usual occupation

11. Industry or business

- 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) _____ (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) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

- 20. DATE OF DEATH: Month Nov 1943 hour _____ minute _____ M.

- 21. I hereby certify that I attended the deceased from _____, 19____; that I have a copy of the _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

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

23. Signature _____ (M. D. or other) _____

Address _____ 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 2

S-11277