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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

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

FILED JAN 5 1944

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 5454

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:  
Trinity Lutheran Hospital  
(If not hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 15 days  
(Specify whether \_\_\_\_\_)

In this community 15 years  
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. 1204 E. 84th Terrace  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME WILLIAM SESSE RICHARDS SR

3. (b) If veteran, name war No. 3. (c) Social Security No. 487-03-6514

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

6. (b) Name of husband or wife Mrs. Cecil Richards 6. (c) Age of husband or wife if alive: 52 years

7. Birth date of deceased February 27, 1886  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>57</u>	<u>9</u>	<u>22</u>	hr. _____ min. _____

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

10. Usual occupation Automobile Mechanic

11. Industry or business Hillside Motor Co.

12. Name William Richards

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

14. Maiden name Ann Hagen

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

16. (a) Informant Mrs. Opa Richards

(b) Address 1204 E. 84th Terrace

17. (a) BURIAL (b) Date thereof DEC-22-1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MT. MORIAH CEMETERY

18. (a) Signature of funeral director D. P. Newcomer

(b) Address 1401 Brush Creek Blvd.

19. (a) 12-21-43 (b) T. E. Brown  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 19<sup>TH</sup>  
year 1943 hour 8 minute 50 A. M.

21. I hereby certify that I attended the deceased from Dec 19, 1943 to Dec 19, 1943  
that I last saw him alive on Dec 19, 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death:

1. Coronary occlusion

2. Arteriosclerotic Cardio-vascular disease

Duration 3 weeks

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

Due to 93h

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

Major findings: Of operations \_\_\_\_\_

Of autopsy As above

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 Gerald B. Peers MD  
Address Trinity Hospital Date signed 12-19-43

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

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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..... *R C Mc*  
Licensed Embalmer No. .... *4043*  
P. O. Address..... *R C Mc*

**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.**