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36671

FILED FEB 4 1944
Registration District No. 313

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County St. Louis Mo.
(b) City or town St. Louis Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Bethesda General Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 hrs.
(Specify whether

In this community _____
years, months or days)

3. (a) PRINT FULL NAME Richardson, Baby #1

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

4. Sex male 5. Color or race w 6. (a) Single, widowed, married, divorced 0

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

7. Birth date of deceased Jan 26 1944
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
2 hr. min.

9. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name James L. Richardson

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

14. Maiden name Dorothy Maurer Mayer

15. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant James L. Richardson

(b) Address 5085 Gevaldine

17. (a) _____ (b) Date thereof Jan 28 44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Catholic Cemetery

18. (a) Signature of funeral director Shad Carroll 2nd

(b) Address 4600 N. Broadway

19. (a) JAN 27 1944 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 5085 Gevaldine
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 26
year 1944 hour 9:30 minute 0 M.

21. I hereby certify that I attended the deceased from 1-26-44, 19____ to 1-26-44, 19____
that I last saw h_____ alive on 1-26-44, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to Respiratory failure
Insufficiency

Due to Cerebral edema
of mother

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

Major findings: Of operations _____

Of autopsy 20

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) Means of injury _____

23. Signature [Signature] (M. D. or other) [Signature]
Address 4600 N. Broadway Date signed 1/27/44

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

2025 GRAYSON-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..... *Frank H. Slout*

Licensed Embalmer No. 2245.....

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.