

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 903  
Registrar's No. 653

FILED FEB 1 1944

Registration District No. 313

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town (If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Missouri Baptist 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 Ida Richmond

3. (b) If veteran, name war None  
3. (c) Social Security No. None

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

6. (b) Name of husband or wife Ralph Richmond  
6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased April 16 1879  
(Month) (Day) (Year)

8. AGE: Years 64 Months 9 Days 4  
If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

12. Name Carol Ferguson

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

14. Maiden name Unknown Harrison

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

16. (a) Informant Mrs. Hazel Dunn

(b) Address Alton, Illinois

17. (a) Removal (b) Date thereof 1-22-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Roodhouse, Illinois

18. (a) Signature of funeral director Albert H. Hoppe, Inc.

(b) Address 4700 Washington Blvd.

19. (a) JAN 21 1944 (b) J. Brebeck  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Macoupin  
(c) City or town Palmyra  
(If outside city or town limits, write "RURAL")  
(d) Street No. 9  
(If rural, give location)  
(e) Citizen of foreign country? (Yes or No)  
If yes, name country 2.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 20  
year 1944 hour 1:45 minute A. M.

21. I hereby certify that I attended the deceased from 12-18 1943, to 1/20 1944  
that I last saw ~~or~~ alive on 1/19 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Meningitis (probably) Tuberculosis  
Duration

Due to

Due to Nephrectomy abscessed kidney (Tuberculosis)

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations abscessed kidney  
PHYSICIAN

Of autopsy Meningitis - probably Tuberculosis  
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. H. H. (M. D. or other)  
Address Metrop. Bldg Date signed 1/22/44

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

MOTHER FATHER

**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

*Albert G. Hopper*

Licensed Embalmer No.

2971

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.**