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FILED FEB 7 1944

State File No.....

Registration District No. 10

Primary Registration District No. 3002

Registrar's No. 2

1. PLACE OF DEATH:

(a) County Audrain  
(b) City or town Mexico  
(If outside city or town limits, write "RURAL," and name of township)  
(c) Name of hospital or institution: Audrain Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 5 weeks  
In this community                       
years, months or days (Specify whether

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Audrain  
(c) City or town Mexico  
(If outside city or town limits, write "RURAL") 3  
(d) Street No. 1025 E. Whitley  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country                     

3. (a) PRINT FULL NAME William Richmond

3. (b) If veteran, name war No 3. (c) Social Security No. 428-24-6644

4. Sex M 5. Color or Race Negro 6. (a) Single, widowed, married, divorced 3

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

7. Birth date of deceased                      1885  
(Month) (Day) (Year)

8. AGE: Years 58 Months DK Days DK If less than one day                      hr.                      min.

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

10. Usual occupation Laborer

11. Industry or business A. P. Green Fire Brick Co.

MOTHER FATHER

12. Name DK

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

14. Maiden name DK

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

16. (a) Informant Nellie M. Walker

(b) Address Richmond, Mo.

17. (a) Burial (b) Date thereof 1/13/48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Elmwood

18. (a) Signature of funeral director                     

(b) Address Mexico, Mo.

19. (a) Jan 13-1944 (b) Margaret H. Mackie  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 11  
year 1944 hour 4:30 minute A M.

21. I hereby certify that I attended the deceased from 12/21/43  
19                      to 1/11 19 44  
that I last saw him alive on 1/10 19 44  
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary tubercu-  
losis Duration                     

Due to                     

Due to                     

Other conditions cardionephritic compli-  
(Include pregnancy within 3 months of death) cations

Major findings:  
Of operations                       
Of autopsy 1341

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?                     

(Specify type of place)  
While at work                      (e) Means of injury                     

23. Signature                      (M. D. or other)                     

Address Mexico, Mo. Date signed 1/11/44

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

RECEIVED

District Health Officer No. 10

District File Number 2-44-252

Date Filed FEB-3-1944

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. 3569

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.