

No. 2
-2-43
-17-39
X35897

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

14101

FILED MAY 13 1944

State File No. 14101
Registrar's No. 109

Registration District No. 38 Primary Registration District No. 3006-3

1. PLACE OF DEATH:
(a) County Boone
(b) City or town Columbia
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 207 McBaine Ave.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
in this community 79 Years (Specify whether
years, months or days)

3. (a) PRINT FULL NAME JOHN TURNER RICHARDSON
3. (b) If veteran, None name war _____
3. (c) Social Security No. _____

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced, Married
6. (b) Name of husband or wife Emma Richardson
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased 10 - 18 - 1864
(Month) (Day) (Year)

8. AGE: Years 79 Months 6 Days 7
If less than one day hr. _____ min. _____

9. Birthplace Boone County Missouri
(City, town, or county) (State or foreign country)
10. Usual occupation Retired Farmer

11. Industry or business _____
12. Name Hugh Richardson
13. Birthplace Virginia
(City, town, or county) (State or foreign country)
14. Maiden name Mary Jane Atkins
15. Birthplace Virginia
(City, town, or county) (State or foreign country)

16. (a) Informant Hartley Richardson
(b) Address Columbia, Mo.

17. (a) Burial (b) Date thereof 4 27 44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Millersburg

18. (a) Signature of funeral director Green Funeral Service
(b) Address Columbia, Mo.

19. (a) 4-27-44 (b) E. Olson T. Barber
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Boone
(c) City or town Columbia
(If outside city or town limits, write "RURAL")
(d) Street No. 207 McBaine Ave.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Apr. day 25
year 1944 hour 6 minute 45 A.M.
21. I hereby certify that I attended the deceased from H-24-HH
19____ to 19____
that I last saw him alive on H-24-HH 19____
and that death occurred on the date and hour stated above.

Immediate cause of death: Coronary Thrombosis
Coronary Duration 12 hrs.

Due to No natural causes

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

Major findings: None
Of operations _____
Of autopsy None

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? _____

While at work? No (Specify type of place)
(e) Means of injury _____
23. Signature W. D. DeWalt (M. D. or other)
Address Columbia, Mo. Date signed 4-25-44

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

MOTHER FATHER

/250

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 9,

District File Number _____

Date Filed 5-12-44

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 W. D. Whitcomb

Licensed Embalmer No. 2893

P. O. Address Calumet, Mich

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.