

U.S. No. 2  
FORM-5-43  
Rev. 5-17-39  
I X36871

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH  
1003

39740

State File No. ....

FILED JAN 15 1945 318  
Registration District No. ....

Primary Registration District No. ....

Registrar's No. 11054

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
3628 N. 11th St.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 (Specify whether years, months or days)

In this community 1 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County New Madrid

(c) City or town Parma  
(If outside city or town limits, write "RURAL")

(d) Street No. .... (If rural, give location)

(e) Citizen of foreign country? 1 (Yes or No)  
If yes, name country .....

3. (a) PRINT FULL NAME William H. Richards

3. (b) If veteran, name war Nil

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Nervie Richards

6. (c) Age of husband or wife if alive 79 years

7. Birth date of deceased February 6 1864  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>80</u>	<u>10</u>	<u>18</u>	hr. min.

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

10. Usual occupation Farmer

11. Industry or business .....

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Lee Richards

(b) Address 3628 N. 11th St.

17. (a) Burial (b) Date thereof 12-27-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Parma, Missouri

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

(b) Address 4700 Washington Blvd.

19. (a) DEC 26 1944 (b) J. F. Budick  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 24  
year 1944 hour 9:20 minute 10 P. M.

21. I hereby certify that I attended the deceased from .....

that I last saw him alive on ....., 19....., to ....., 19.....  
and that death occurred on the date and hour stated above.

Immediate cause of death .....

Cerebral Anoxia

Due to .....

Due to .....

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

Major findings:  
Of operations .....

Of autopsy .....

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? .....

(d) Did injury occur in or about home, on farm, in industrial place, in public place? .....

While at work? .....

(Specify type of place) (a) Means of injury .....

23. Signature Alfred J. Perry (M. D. or other) 3  
Address Deputy Coroner Date signed 12-26-44

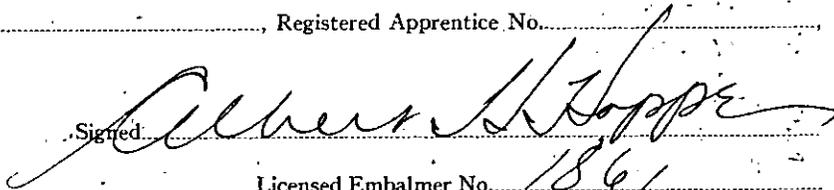
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

**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.....



Licensed Embalmer No. 1861

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.**