

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

Registration District No. 156

Primary Registration District No. 2001

1. PLACE OF DEATH:

(a) County Jasper

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

(c) Name of hospital or institution:  
St Johns Hospital  
(If not in hospital or institution, write street number or location)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Oklahoma (b) County Ottawa 999

(c) City or town Wyandotte 34  
(If outside city or town limits, write "RURAL")

(d) Street No. Rural 0  
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)  
If yes, name country. 2

3. (a) PRINT FULL NAME Sam Richardson

3. (b) If veteran, name war No.

3. (c) Social Security No.

4. Sex male 0

5. Color or race white

6. (a) Single, widowed, married, divorced, widowed 2

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

7. Birth date of deceased Sept. 27, 1872  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
72	3	5	hr. min.

9. Birthplace Tenn. 1  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

12. Name Redmond Richardson

13. Birthplace Tenn. 1  
(City, town, or county) (State or foreign country)

14. Maiden name unknown

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

16. (a) Informant V. D. Cooper

(b) Address Miami Okla.

17. (a) removal (b) Date thereof 1, 3, 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wyandotte Okla.

18. (a) Signature of funeral director Cooper Funeral Home

(b) Address Miami Okla.

19. (a) 1-10-45 (b) J. H. ...  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 1st  
year 1945 hour 4 minute 20 P.M.

21. I hereby certify that I attended the deceased from 12/9, 1944 to 1/1, 1945  
that I last saw him alive on 1/1/45  
and that death occurred on the date and hour stated above.

Immediate cause of death. uremia

Due to Pyelonephritis 1 mo.

Due to C. a. Prostate 6 mo.

Other conditions Broncho pneumonia 3 days  
(Include pregnancy within 3 months of death)

Major findings: Of operations Cystoscopic examination  
C. a. Prostate  
Of autopsy none 5/1

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? (Specify type of place) (c) Means of injury

23. Signature E. Ernest Johnson M.D. or other  
Address 617 ... Date signed 1/10/45

1204 (Licensed Embalmer's Statement on Reverse Side)

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

9  
2  
5  
Joplin

45-1-7

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**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 Steve Parker

Licensed Embalmer No. 2548

P. O. Address Johns Rd

**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.**