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FILED JAN 12 1945

Primary Registration District No. 3043-5765

Registrar's No. 374

1. PLACE OF DEATH:

(a) County Marion

(b) City or town Hannibal (Rural) Marion Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Mt. Olivet Heights
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community 22 yrs.
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Marion

(c) City or town Hannibal - (Rural)
(If outside city or town limits, write "RURAL")

(d) Street No. Mt. Olivet Heights
(If rural, give location)

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

3. (a) PRINT FULL NAME John Fred Richardson

3. (b) If veteran, 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 Mellie Richardson

6. (c) Age of husband or wife if alive 67 years

7. Birth date of deceased Sept 30 1869
(Month) (Day) (Year)

8. AGE: Years 75 Months 1 Days 11 If less than one day hr. _____ min. _____

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

10. Usual occupation Truck Farmer

11. Industry or business Farming

12. Name John Richardson

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

14. Maiden name Mary Harvey

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

16. (a) Informant Mrs. Mellie Richardson

(b) Address Mt. Olivet Heights

17. (a) Burial (b) Date thereof Nov 14 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Olivet

18. (a) Signature of funeral director Ray P. Schouty

(b) Address 1000 Broadway

19. (a) 11-25-44 (b) W. Morrison
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 11
year 1944 hour 8 minute 00 P.M.

21. I hereby certify that I attended the deceased from Dec 16-1943
to Nov 11 1944
that I last saw him alive on Nov 11 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage
1 yr

Due to Hypertension

Due to Nephritis

Other conditions Chronic Myocarditis
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 W.P. Beverly (M. D. or other) M.D.
Address Hannibal Mo Date signed 11-17-44

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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 *Jack H. L...*
Licensed Embalmer No. 4110
P. O. Address *Memphis, Tenn*

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.

Registration District No. 209

Primary Registration District No. 5765

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

1. PLACE OF DEATH:

(a) County Marion
(b) City or town Rural Marion Twp.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(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 John F. Richardson

3. (b) If veteran name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

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

7. Birth date of deceased Sept 30
(Month) (Day) (Year)

8. AGE: Years 75 Months _____ Days _____ (less than one day) _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Year 1944 Hour _____ Minute 00 M.

21. I hereby certify that I attended the deceased from _____ 19____
that I last saw him _____ alive on _____ 19____
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration

Due to _____

Due to chronic

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? _____
(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 W. Birney (M.D. or other) _____

Address _____ Date signed _____

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