

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 9 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 1795

Registration District No. 318

Primary Registration District No. 1003

1. PLACE OF DEATH:
(a) County St. Louis, Mo.
(b) City or town St. Louis, Mo.
(c) Name of hospital or institution: 5200 Nottingham
(d) Length of stay: In hospital or institution. 50 YEARS
In this community 50 YEARS

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 000
(c) City or town St. Louis
(d) Street No. 5200 Nottingham
(e) Citizen of foreign country? No (Yes or No)

3. (a) PRINT FULL NAME: Allen P. Richardson
3. (b) If veteran, name war: None
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: Bertha Richardson
6. (c) Age of husband or wife if alive: 65 years
7. Birth date of deceased: May 11 1858

8. AGE: Years 86 Months 9 Days 11
If less than one day hr. min.

9. Birthplace: Jefferson City, Mo.

10. Usual occupation: Retired Building Contractor

11. Industry or business:

12. Name: Allen P. Richardson
13. Birthplace: Missouri
14. Maiden name: Fannie King
15. Birthplace: Missouri

16. (a) Informant: Mrs. A. P. Richardson
(b) Address: 5200 Nottingham

17. (a) Burial (b) Date thereof: 2-24-45
(c) Place: burial or cremation: Oak Grove Mausoleum

18. (a) Signature of funeral director: Wagoner Mortuary
(b) Address: 4161 Lindell Blvd.

19. (a) FEB 23 1945 (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Feb day 22
year 1945 hour 8 minute 10 A.M.
21. I hereby certify that I attended the deceased from 2/19 1945 to 2-22-45
that I last saw him alive on 2-21-1945
and that death occurred on the date and hour stated above.
Immediate cause of death: Coronary thrombosis
Duration: 2 hrs

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?

23. Signature: E. H. Edwards M.D.
Address: 4030 Chouteau
Date signed: 2/23/45

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

MOTHER FATHER

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 *Melvin F. Kemper*

Licensed Embalmer No. *405-2*

P. O. Address *4005 Lexington*

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.