

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

13578

State File No. _____

FILED MAY 9 1945
Registration District No. 1444

Primary Registration District No. 4234

Registrar's No. 9

1. PLACE OF DEATH:

(a) County Iron

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

(c) Name of hospital or institution St. Mary's the Ozarks
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution About 4 weeks.
(Specify whether In this community _____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Madison

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

(d) Street No. W. R. #1
(If rural, give location)

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

3. (a) PRINT FULL NAME SIMON - Richards -

3. (b) If veteran, / name war _____

3. (c) Social Security No. /

4. Sex M Color or race W

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased: Jan. 20 1935
(Month) (Day) (Year)

8. AGE: Years 10 Months 2 Days 28
If less than one day _____ hr. _____ min.

9. Birthplace Madison Co. Mo
(City, town or county) (State or foreign country)

10. Usual occupation School Boy

11. Industry or business _____

12. Name Joseph Richards

13. Birthplace Madison Co. Mo
(City or town or county) (State or foreign country)

14. Maiden name Apple Jansen

15. Birthplace Madison Co. Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Thomas Richards

(b) Address Fredricksburg Mo. R. 1, #2

17. (a) Burial (b) Date thereof Apr. 20 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Fredricksburg Mo

18. (a) Signature of funeral director Walter H. H. H.

(b) Address Fredricksburg Mo.

19. (a) April 21, 1945 (b) Mo & E. J. Jovan
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 18
year 1945 hour 5:00 minute 20 a. M.

21. I hereby certify that I attended the deceased from 3-20-45, 19____ to 4-18-45, 19____
that I last saw him alive on 4-18-45, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death acute cardiac failure Duration _____

Due to acute Endocarditis 4/18/45

Due to acute Rheumatic Fever 10/1/44

Other conditions infected tonsils
(Include pregnancy within 3 months of death)

Major findings: Of operations none -

Of autopsy none H5c

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 R. E. J. Jovan (M. D. or other) M. D.
Address Ironton, Mo. Date signed 4-19-45

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

7
1
0

1365

RECEIVED

District Health Officer No. 4
District File Number 545-555
Date Filed 5-29-45

MAY 27 1945

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 John H. Helt
Licensed Embalmer No. 4264
P. O. Address Fredricktown

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.