

S. No. 2
M-2-43
7-5-17-39
P-1 X35697

23171

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 2807

FILED JUL 17 1945
Registration District No. 149

Primary Registration District No. 1002

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

1. PLACE OF DEATH:
(a) County JACKSON
(b) City or town KANSAS CITY
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: LAKESIDE HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 17 DAYS
In this community 17-DAYS
(Specify whether years, months or days)

3. (a) PRINT FULL NAME MILDRED MRS. RUBY RICHARDSON
3. (b) If veteran, name war NO
3. (c) Social Security No. NONE

4. Sex FEMALE 5. Color or race WHITE
6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife MR. EARL RICHARDSON
6. (c) Age of husband or wife if alive 44 years
7. Birth date of deceased MARCH-26-1902
(Month) (Day) (Year)

8. AGE: Years 43 Months 3 Days 8
If less than one day hr. min.

9. Birthplace LOVE ROCK IOWA
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSEWIFE

11. Industry or business _____

MOTHER FATHER {
12. Name JOHN BRILEY
13. Birthplace WEST VIRGINIA
(City, town, or county) (State or foreign country)
14. Maiden name ICE HOUSEHOLDER
15. Birthplace WEST VIRGINIA
(City, town, or county) (State or foreign country)

16. (a) Informant MR EARL RICHARDSON
(b) Address R.R. #2 WARSAW MISSOURI

17. (a) BURIAL (b) Date thereof JULY-4-1945
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation WARSAW, MISSOURI

18. (a) Signature of funeral director W. H. Newman
(b) Address 1401- BRUSH CREEK BLVD

19. (a) 7-4-45 (b) Sheraldine Holmes
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County BENTON
(c) City or town RURAL
(If outside city or town limits, write "RURAL")
(d) Street No. R.R. #2 WARSAW
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month JULY day 4TH
year 1945 hour 9 minute 35 A.M.

21. I hereby certify that I attended the deceased from June 18 1945 to July 4 1945
that I last saw her alive on July 3 1945
and that death occurred on the date and hour stated above.

Immediate cause of death: Coronary & cerebral thrombosis
Decompensation
Due to: Arterio-sclerosis & interstitial years
Due to: hypertension & complications
(Menstrual - metastasis)
Other conditions: pregnancy - 3 mo.
(Include pregnancy within 3 months of death)
no delivery

Major findings: hypertension - 0
non-viable fetus
Of autopsy 45.1

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. J. Schindler (M. D. or other) D.O.
Address 421 S. Hubert Bldg Date signed 7/4/45

7.

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. 4043

P. O. Address A. C. Mo.

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