S. No. 2
OM—5-43
v. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 31506

FILED OCT 23 1945

Registration District No. 6 Primary Registration District No. 6076 Registrar's No. 2337

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution: # 28 Upper Ladue Road /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ (Specify whether
In this community 2-years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 060

(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")

(d) Street No. Park Plaza Hotel 9
(If rural, give location)

(e) Citizen of foreign country? ____ (Yes or No) /

If yes, name country ____

3. (a) PRINT FULL NAME Henry Thomas Richardson

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

4. Sex M.0 5. Color or race W. 6. (a) Single, widowed, married, divorced M. /

6. (b) Name of husband or wife Katharine Richardson 6. (c) Age of husband or wife if alive 42 years

7. Birth date of deceased March 25th., 1900
(Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
45	6	12	____ hr. ____ min.

9. Birthplace ____ (City, town, or county) N.Y. / (State or foreign country)

10. Usual occupation Ass. Sales Mangr.

11. Industry or business Carnage Steel Corp.

FATHER
12. Name Davis Richardson
13. Birthplace ____ (City, town, or county) N.Y. / (State or foreign country)

MOTHER
14. Maiden name Stella Van Auden
15. Birthplace ____ (City, town, or county) N.Y. / (State or foreign country)

16. (a) Informant Mrs. Katharine Richardson
(b) Address Park Plaza Hotel

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 10-8-45 (Month) (Day) (Year)
(c) Place: burial or cremation New York City

18. (a) Signature of funeral director Arthur H. Donnelly
(b) Address 3840 Lindell Blvd.

19. (a) 10-8-45 (Date received local registrar) (b) Ed. Dr. Hoiman M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 7th., year 1945 hour 9 minute p. M.

21. I hereby certify that I attended the deceased from Death without medical attendance, to ____, 19____; that I last saw h. alive on ____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Ill-defined and Unknown	Duration
Due to 200	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations ____
Of autopsy No 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? ____ (Specify type of place)
While at work? ____ (e) Means of injury ____

23. Signature ____ M.D. (M. D. or other)
Address 601 Brentwood Blvd. Date signed 10/8/45

(Licensed Embalmer's Statement on Reverse Side)

Cou[redacted]spital

Dr Brey Foyle

APR 10 1946

OCT 27 1945

AUG 27 1947

OCT 22 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 Stanley Marshall

Licensed Embalmer No. 2868

P. O. Address 3840 Kindell

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.