

FILED MAR 8 1946
Registration District No. 42

Primary Registration District No. 1000

State File No. _____

Registrar's No. 147

1. PLACE OF DEATH:

(a) County Speelman
(b) City or town St. Joseph
(c) Name of hospital or institution St. Joseph # 1 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 mo 15 days
(Specify whether
In this community all his life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Buchanan
(c) City or town St. Joseph
(If outside city or town limits, write "RURAL")
(d) Street No. 906 N Valley
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME LORAIN Lawrence Richardson

(b) If veteran, name war none (c) Social Security No. none

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Josephine Robinson 6. (c) Age of husband or wife if alive 64 years
7. Birth date of deceased Nov 26 1882
(Month) (Day) (Year)

8. AGE: Years 73 Months 3 Days 6 If less than one day hr. _____ min. _____

9. Birthplace St. Joseph Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Painter

11. Industry or business _____

MOTHER FATHER

12. Name Mrs Richardson
13. Birthplace Mo
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Josephine Robinson
(b) Address 906 N Valley St. Joe

17. (a) Burial (b) Date thereof 2/14/46
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Ashland Cemetery

18. (a) Signature of funeral director Rupp Funeral Home
(b) Address 6054 Pryor St. Joseph Mo

19. (a) Feb 3, 1946 (b) L. J. Meathurst
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 2
year 1946 hour 5:15 minute P. M.

21. I hereby certify that I attended the deceased from 2-1 1946 to 2/2 1946
that I last saw him alive on 2-1 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia
Duration 1 day

Due to _____

Due to _____

Other conditions _____
(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?

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature L. J. Meathurst (M. D. or other) _____
Address State Hospital #2 Date signed 2/2/46
St. Joseph Mo.

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.....

Mollie E. Lindenfaden Jr

Licensed Embalmer No. *4235*

P. O. Address. *St. Joseph, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Mar
Registrar's No. 187

Registration District No. 42 Primary Registration District No. 1000

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town St Joseph
(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 _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Joran L. 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 _____
7. Birth date of deceased 04 26 (Month) (Day) (Year)

8. AGE: Years 73 Months 3 Days 6 If less than one day hr. _____ min. _____

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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 _____ (Month) (Day) (Year)
(Burial, cremation, or removal) (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 Mar Year 1946 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy 107

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? _____
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature L. J. [unclear] (M. D. or other) _____
Address _____ Date signed 3/14/46

SUPPLEMENTARY

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

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