

FILED MAR 5 1946
Registration District No. **328**

Primary Registration District No. **3073**

Registrar's No. **7**

1. PLACE OF DEATH:
(a) County **Scott**
(b) City or town **Chaffee Missouri**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
115 W. Parker Ave.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2 yrs.** (Specify whether years, months or days)
In this community **2 yrs.**

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo.** (b) County **Scott**
(c) City or town **Chaffee Mo.**
(If outside city or town limits, write "RURAL")
(d) Street No. **115 W. Parker Ave.** (If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Robert Douglas Richbourg**
3. (b) If veteran, name war **"** **3. (c) Social Security No.** **"**

4. Sex **male** **5. Color or race** **White** **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 **Sept. 12 1940**
(Month) (Day) (Year)

8. AGE: Years **5** Months **5** Days **4** If less than one day _____ hr. _____ min.

9. Birthplace **Nashville Tennessee**
(City, town, or county) (State or foreign country)

10. Usual occupation **infant**

11. Industry or business **"**

12. Name **C. C. Richbourg**
13. Birthplace **Steelcity Nebraska**
(City, town, or county) (State or foreign country)
14. Maiden name **Nell G. Williams**
15. Birthplace **Albany Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant **C. C. Richbourg**
(b) Address **Chaffee Missouri**

17. (a) Removal **(b) Date thereof** **2-18-46**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Springhill Cem-Nashville Tenn.**

18. (a) Signature of funeral director **(b) Address** **Chaffee Missouri**

19. (a) 2/16/46 **(b) H. B. Macready**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb** day **16** year **1946** hour **7** minute **30 A.M.**

21. I hereby certify that I attended the deceased from **Feb 10 1946** to **Feb 16 1946**
that I last saw **him** alive on **Feb 10**, 19____;
and that death occurred on the **date** and hour stated above.

Immediate cause of death **Asphyxia -**
Asphyxia -
Pulmonary Edema
Due to **Maturation**
Asphyxia
Asphyxia
Other conditions **Edema**
(Include pregnancy within 3 months of death)

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

Major findings:
Of operations _____
Of autopsy **106e**

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 **H. B. Macready** (M. D. _____)
Address **Chaffee Mo.** Date signed **2-16**

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

MOTHER FATHER

RECEIVED

District Health Office No. 2,

District File Number 346-290

Date Filed 3-4-46

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

C. J. Loring

Licensed Embalmer No. 3870

P. O. Address Cape Girardeau, 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.