

FILED MAY 16 1946

Registration District No. 01

Primary Registration District No. 3063

Registrar's No. 973

1. PLACE OF DEATH:

(a) County St. Louis County
 (b) City or town Clayton
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: St. Louis County 0
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 6 1/2 hrs.
(Specify whether in this community _____ years, months or days) City St. Louis resident

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County City of St. Louis 160
 (c) City or town St. Louis Louis 17
(If outside city or town limits, write "RURAL")
 (d) Street No. 1525a N. 8th St.
(If rural, give location) 9
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME THOMAS RICHMOND

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 None 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased 9 8 74
(Month) (Day) (Year)

8. AGE: Years 71 Months 8 Days 24
 If less than one day _____ hr. _____ min.

9. Birthplace St. Louis, Missouri 0
(City, town, or county) (State or foreign country)

10. Usual occupation Yardman

11. Industry or business _____

12. Name John Richmond

13. Birthplace St. Louis, Missouri 0
(City, town, or county) (State or foreign country)

14. Maiden name Kate Harvey

15. Birthplace St. Louis, Missouri 0
(City, town, or county) (State or foreign country)

16. (a) Informant Cousin: Ann Gallagher

(b) Address Ro: 0083 or Lo: 6875

17. (a) Burial (b) Date thereof 5-4-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Cullinane Bros.

(b) Address 3320 N. Kingshighway Blvd.

19. (a) 5-6-46 (b) E. Mc Garrison MD
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 2nd
 year 1946 hour 3 minute 45 p. M.

21. I hereby certify that I attended the deceased from May 2nd, 9:20am 1946 May 2, 3:45pm 1946
 that I last saw him im alive on May 2nd 1946
 and that death occurred on the date and hour stated above.

Immediate cause of death Suicidal hematemesis 1 day

Due to fractured skull 1 day

Due to hypertension ?

Other conditions hypertension ?
(Include pregnancy within 6 months of death)

Major findings: Of operations _____

Of autopsy as above

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) suicide 000

(b) Date of occurrence 5/2/46

(c) Where did injury occur? Home of Employer
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Home of Employer
(Specify type of place)
 While at work? ? (b) Means of injury unknown

23. Signature James B. Vatterett (M. D. or other) MD

Address St. Louis Co Hosp Date signed 5/3/46
Vatterett

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

MOTHER FATHER

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.....

Fred Frick

Licensed Embalmer No..... **3186**.....

P. O. Address..... **St. Louis, 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.

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

State File No.

June

Registration District No.

317

Primary Registration District No.

3063

Registrar's No.

973

1. PLACE OF DEATH:

- (a) County St Louis
- (b) City or town clayton
(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

Thomas Richmond3. (b) If veteran,
name war _____3. (c) Social Security
No. _____4. Sex m 5. Color or race w6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
alive _____ years7. Birth date of deceased: aug 8 1946
(Month) (Day) (Year)8. AGE: Years 21 Months _____ Days _____ (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 _____

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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) 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 2
year 1946 hour _____ minute _____ M.21. I hereby certify that I attended the deceased from _____ to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)Major findings:
Of operations _____Of autopsy _____ 1860-5
18

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide (specify) accident
- (b) Date of occurrence _____
- (c) Where did injury occur? _____ (City or town) (County) (State) over
- (d) Did injury occur in or about home, on farm, in industrial place, in public place?
Home

While at work? _____ (Specify type of place) (e) Means of injury Fall23. Signature Paul B. Watterud (M. D. or other) MD
Address St Louis Co Hosp Date signed 2/2/46

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

SUPPLEMENTARY

ADDITIONAL
SUPPLEMENTARY
INFORMATION
REQUESTED

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

16786

This patient was found slumped in
a wicker chair, at foot of stairs. It is thought
and has been investigated by the coroner) that the
patient fainted, struck his head & fractured
his skull.

B. W. Atterton

17907