

**FILED SEP 23 1946**

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 727

**1. PLACE OF DEATH:**

(a) County Cass  
(b) City or town Springfield  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Burgess Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_ years, months or days

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Christian  
(c) City or town Oldfield  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Baby Boy Richardson

3. (b) If veteran, name war None 3. (c) Social Security No. None

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 XX years

7. Birth date of deceased Sept. 1, 1946  
(Month) (Day) (Year)

8. AGE: Years 0 Months 0 Days 0 13 hr. \_\_\_\_\_ min.

9. Birthplace Oldfield Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Infant

11. Industry or business \_\_\_\_\_

12. Name Lee Richardson

13. Birthplace Christian Co. Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name Bordley Gilley

15. Birthplace Smith Center Kansas  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Lois Gilley (grandmother)

(b) Address 449 W. Pigeon Street

17. (a) Removal (b) Date thereof Sept. 2, 1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oldfield, Mo.

18. (a) Signature of funeral director Family dispo. - Removed by father - Lee Richardson  
(b) Address Oldfield, Mo.

19. (a) 9-2-46 (b) W. B. Busey M.D.  
(Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Sept day 1  
year 1946 hour 7 minute 15 p. M.

21. I hereby certify that I attended the deceased from 9-1-1946 to 9-1-1946  
that I last saw him alive on 9-1-46, 19\_\_\_\_ and that death occurred on the date and hour stated above.

Immediate cause of death Premature Birth

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Congenital Abnormalities  
(Includes pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy 159

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? \_\_\_\_\_

(e) Means of injury \_\_\_\_\_

23. Signature W. B. Busey (M. D. or other) \_\_\_\_\_  
Address Springfield, Mo. Date signed 9-2-46

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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**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.....

P. O. Address.....

**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.**

