

FILED SEP 23 1946

Registration District No. 2000

Primary Registration District No. 2000

Registrar's No. 731

1. PLACE OF DEATH:

(a) County Greene  
(b) City or town Springfield  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution Burge Hosp.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: 1 hospital or institution 8 hours  
(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? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 2  
year 1946 hour 4 pm minute 17 M.  
21. I hereby certify that I attended the deceased from 1 Sept  
1946 to 2 Sept 1946  
that I last saw him alive on 1 Sept 46  
and that death occurred on the date and hour stated above.

Immediate cause of death apoplexias of lungs  
congenital

Duration

1 day

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(include pregnancy within 3 months of death)

PHYSICIAN

Major findings:  
Of operations 161A  
Of autopsy \_\_\_\_\_  
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 R. J. Rogers M.D. (M. D. or other)  
Address Opark, Mo. Date signed 6 Sept 46

3. (a) PRINT FULL NAME Ricky Dane 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 Infant

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. 1946  
(Month) (Day) (Year)

8. AGE: Years 0 Months 0 Days 0 If less than one day 13 hr. \_\_\_\_\_ min.

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

10. Usual occupation INFANT

MOTHER FATHER

11. Industry or business \_\_\_\_\_  
12. Name Lee David Richardson  
13. Birthplace Oldfield Mo.  
(City, town, or county) (State or foreign country)  
14. Maiden name Dorothy Gilley  
15. Birthplace Smith Center Kans.  
(City, town, or county) (State or foreign country)

16. (a) Informant Lee Richardson  
(b) Address Oldfield, Mo.

17. (a) Burial (b) Date thereof Sept-2-46  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Smith Cemetery Oldfield

18. (a) Signature of funeral director John Harris  
(b) Address Chadwick, Mo.

19. (a) 9-6-46 (b) M. J. Handley M.D.  
(Date received local registrar) (Registrar's signature)

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

6  
2  
9

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was <sup>not</sup> embalmed by me, or by.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

*John Harris*  
.....  
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.**