

2-45
7-39
X47070

FILED FEB 3 1947

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. _____

1. PLACE OF DEATH:

(a) County _____

(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Peoples Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **3 Days** (Specify whether _____)

In this community **5 years**
years, months or days

3. (a) PRINT FULL NAME: Veatrice Richardson

3. (b) If veteran, name war. **no**

3. (c) Social Security No. **no card**

4. Sex **Female** 5. Color or race **Col.**

6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **John F. Richardson**

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **June 17, 1900**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
46	6	29	hr. _____ min.

9. Birthplace **Madison Parrish La.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business _____

MOTHER FATHER

12. Name **Joe Mills**

13. Birthplace **Madison Parrish, La.**
(City, town, or county) (State or foreign country)

14. Maiden name **Luvina Coleman**

15. Birthplace **Baton Rouge, La.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Lettie Aitch**

(b) Address **3914 Fairfax Ave.**

17. (a) **Burial** (b) Date thereof **Jan, 20, 1947**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Father Dickson Cemetery**

(e) Signature of funeral director **Wright's Funeral Home.**

(b) Address **3100 Easton Ave.**

19. (a) **JAN 20 1947** (b) **J. F. Bredek**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **one**

(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")

(d) Street No. **3914 A. Fairfax**
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan.** day **16** year **1947** hour **11** minute **35 a.m.**

21. I hereby certify that I attended the deceased from **Jan 1 - 47** to **Jan 16 - 47** that I last saw her alive on **Jan 16 - 47** and that death occurred on the date and hour stated above.

Immediate cause of death **Infection, Arthritis**

Due to **= allergy**

Duration **3 mths**

Due to _____

Other conditions **7/5/6**
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:
Of operations _____
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 **Willpunge** (M. D. or other) _____

Address **7337 milled** Date signed **1/17/47**

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

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 *Arthur L. Hilliard*

Licensed Embalmer No. *4221*

P. O. Address *1154 Bayard ave*

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.