No. 2
-8-43
17-39
X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 28 1947

Registration District No. 76

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 34084

Primary Registration District No. 5353

Registrar's No. 62

1. PLACE OF DEATH:

(a) County DALLAS

(b) City or town ELKLAND RURAL
(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 4 YRS
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County DALLAS 30

(c) City or town ELKLAND RURAL 2
(If outside city or town limits, write "RURAL")

(d) Street No. 0
(If rural, give location) 0

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

If yes, name country .....

3. (a) PRINT FULL NAME ROBERT RICHERSON

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 MARRIED

6. (b) Name of husband or wife Isabelle

6. (c) Age of husband or wife if alive 66 years

7. Birth date of deceased DEC 6 1876
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
70	10		..... hr. ..... min.

9. Birthplace CHARITY (City, town, or county) MO (State or foreign country)

10. Usual occupation FARMER

11. Industry or business .....

FATHER
12. Name JAMES W. RICHERSON
13. Birthplace ..... (City, town, or county) TENN (State or foreign country)

MOTHER
14. Maiden name ARENE BOWMAN
15. Birthplace ..... (City, town, or county) TENN (State or foreign country)

16. (a) Informant MRS EDNA GARRETT

(b) Address RED TOP MO

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 10-8-47 (Month) (Day) (Year)

(c) Place: burial or cremation OAK LAWN

18. (a) Signature of funeral director L B JONES

(b) Address BUFFALO MO

19. (a) Oct 19, 1947 (Date received local registrar) (b) Mrs. J. B. Jones (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCT day 6
year 1947 hour 6 minute 20 P.M.

21. I hereby certify that I attended the deceased from Sept 1, 1947 to Oct 6, 1947 that I last saw him alive on Oct 6, 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral hemorrhage	30 da's
Due to Hypertension & Arterio sclerosis	years
Due to	
Other conditions Chronic Nephritis (Include pregnancy within 3 months of death)	years

Major findings:
Of operations None 131 B

Of autopsy none

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) .....

(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? ..... (Specify type of place)

While at work? ..... (e) Means of injury .....

23. Signature G C Pheminer (M. D. or other) MD

Address Buffalo Mo Date signed 10-16-47

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7
District Number 9-47-1249
Date Filed 10-27-47

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 Leonard B. Jones

Licensed Embalmer No. 2508

P. O. Address Buffalo 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.