FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED NOV 25 1947
Registration District No. 327

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 6076

State File No. 40547
Registrar's No. 2369

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

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Koch (rural)
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Robert Koch Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1341 days (Specify whether
In this community Life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 000
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 1529 Franklin 9
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No) 1
If yes, name country

3. (a) PRINT FULL NAME RICHARDSON, CARRIE
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex Female 3
5. Color or race Negro
6. (a) Single, widowed, married, divorced Separated 1
6. (b) Name of husband or wife Warren Richardson
6. (c) Age of husband or wife if alive years
7. Birth date of deceased April (Month) 20 (Day) 1917 (Year)

8. AGE:	Years	Months	Days	If less than one day
	30	6	26	hr. min.

9. Birthplace St. Louis (City, town, or county) Missouri (State or foreign country) 0
10. Usual occupation Nil
11. Industry or business
FATHER
12. Name John Hearns 9
13. Birthplace (City, town, or county) ?? (State or foreign country) 1
MOTHER
14. Maiden name Edith Payne
15. Birthplace St. Louis (City, town, or county) Missouri (State or foreign country) 0
16. (a) Informant Robert Koch Hospital
(b) Address Koch, Missouri
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-19-47 (Month) (Day) (Year)
(c) Place: burial or cremation Oak Dale Cemetery
18. (a) Signature of funeral director Jinkie Torrey
(b) Address 312 Lucas Ave
19. (a) 11-20-47 (Date received local registrar) (b) Carl A. Sharp MD (Registrar's signature) MD

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 15
year 1947 hour 3 minute 40 A.M.

21. I hereby certify that I attended the deceased from 3-14- 1944, to 11-15 - 1947
that I last saw her alive on 11-15- 1947
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Pulmonary Tuberculosis	4 yrs. (??)
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death): Tuberculous Laryngitis	
Major findings: Of operations	
Of autopsy	

13b

PHYSICIAN
Underline the cause of 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) 0
While at work? (e) Means of injury

23. Signature Bernard Friedman (M. D. or other) M.D.
Address Robert Koch Hospital Date signed 11-15-47

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

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 wit the above constitutes grounds for revocation of license.)

If this body is not embalmed. fact should be so stated above.