

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

44665

State File No.

Registrar's No.

National Office of Vital Statistics

FILED FEB 3 1948 376

Registration District No.

Primary Registration District No. 6 282

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

1. PLACE OF DEATH:

(a) County Wright

(b) City or town Norwood *Black Pop*
(If outside city or town limits, write "RURAL" and name of township)

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

(d) Length of stay: In hospital or institution. Lifetime (Specify whether years, months or days)

3. (a) PRINT FULL NAME Naomi Ruth Richardson

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife X

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

7. Birth date of deceased December 28, 1947
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
			<u>3</u>hr.min.

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

10. Usual occupation X

11. Industry or business X

12. Name Guy Richardson

13. Birthplace Kentucky
(City, town, or county) (State or foreign country)

14. Maiden name Alba E. Cole

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

16. (a) Informant Guy Richardson

(b) Address Mountain Grove, Mo.

17. (a) Burial (b) Date thereof 1/4/48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Thomas Cemetery

18. (a) Signature of funeral director Norwood

(b) Address Mountain Grove, Mo.

19. (a) 2-7-48 (b) Mrs. R. W. ...
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Wright *114*

(c) City or town Mountain Grove
(If outside city or town limits, write "RURAL")

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

(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. 30 day 1947
year.....hour.....minute.....M.

21. I hereby certify that I attended the deceased from 5:30 P.M.
27 1947 to 2:30 30 1947;
that I last saw him alive on 27 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia

Due to Coal

Due to.....

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....

Of autopsy.....

PHYSICIAN

Underline the cause of death which death should be reported stat-
istically.

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 R. P. ... (M. D. or other)
Address Norwood Date signed 1/8

MOTHER FATHER

RECEIVED

District Health Officer No. 6,

District File Number 148-133

Date Filed JAN 29 1948

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

Russell Barber

Licensed Embalmer No.

3848

P. O. Address

Mt. Grove, Pa.

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.

Registration District No. 376 Primary Registration District No. 1282

1. PLACE OF DEATH: Wright Normal
 (a) County _____
 (b) City or town _____
 (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 _____
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State _____ (b) County _____
 (c) City or town _____
 (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 _____

3. (a) PRINT FULL NAME Naomi Ruth Richardson
 3. (b) If veteran, name war _____
 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Feb Day 14 Year 1941 hour _____ minute _____ M.
 21. I hereby certify that I attended the deceased from _____ to _____, 19____
 that I last saw him _____ alive on _____, 19____
 and that death occurred on the date and hour stated above.
 Immediate cause of death: Bronchial Pneumonia

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced _____
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____
 7. Birth date of deceased Dec 28
 (Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace: _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 2-7-48 (b) Mrs. A. R. Washburn
 (Date received local registrar) (Responsible signature)

Other conditions _____
 (Include pregnancy within 3 months of death)
 Major findings:
 Of operations _____
 Of autopsy _____ 107
 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? _____
 While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____
 Address _____ Date signed _____

SUPPLEMENTARY

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

X43880

S-44665