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

#81842
FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED FEB 20 1948

UNITED STATES DEPARTMENT OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **6929**

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **1426**

1. PLACE OF DEATH:
(a) County **St. Louis, Missouri.**
(b) City or town **St. Louis, Missouri.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis City Hospital-Max C. Starkloff
(If not in hospital or institution, write street number or location) **Memorial**
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State **MO** (b) County **000**
(c) City or town **ST LOUIS** **17**
(If outside city or town limits, write "RURAL")
(d) Street No. **2840a** **PARK** **9**
23 (If rural, give location) **0**
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

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

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Feb.** day **9th**
year **1948** hour **9** minute **00** A. M.
21. I hereby certify that I attended the deceased from **1/26/48**
_____ 19____ to **Feb. 9th** 19**48**
that I last saw him alive on **Feb. 9th** 19**48**
and that death occurred on the date and hour stated above.

4. Sex **M.** 5. Color or race **W**
6. (a) Single, widowed, married, divorced **M**
6. (b) Name of husband or wife **ALICE RICHARDSON**
6. (c) Age of husband or wife if alive **30** years
7. Birth date of deceased **MAR 17 1902**
(Month) (Day) (Year)

Immediate cause of death _____
Carcinomatous
Primary Site unknown
Duration **months**
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

8. AGE: Years **45** Months **10** Days **28**
If less than one day _____ hr. _____ min.

Major findings:
Of operations _____
Of autopsy **Widow**
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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

10. Usual occupation **DRIVER**

11. Industry or business **FREIGHT SERVICE**

12. Name **ALEXANDER RICHARDSON**

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

14. Maiden name **JUSAN MASON**

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

16. (a) Informant **ALICE RICHARDSON**

(b) Address **2840a PARK**

17. (a) **BURIAL** (b) Date thereof **2-11-48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **ST. MATTHEWS**

18. (a) Signature of funeral director **E. J. Schurr**

(b) Address **3125 LA FAYETTE**

19. (a) **FEB 11 1948** (b) **J. F. BAUER**
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) **None**
(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) (Means of injury)
23. Signature **White** **1515 Lafayette** **2/9/48**
Address _____ (M. D. or other) **Mo.**
Date signed _____

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. *4014*

P. O. Address *3125 La Fayette Hwy*

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. MarchRegistration District No. 318Primary Registration District No. 1003Registrar's No. 1426

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:

(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)3. (a) PRINT
FULL NAME. Lawrence Richardson

3. (b) If veteran, name war.....
 3. (c) Social Security No.....

4. Sex m 5. Color of race w
 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife.....
 6. (c) Age of husband or wife if alive.....

7. Birth date of deceased March 17
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
45 10 10 hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER { 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) 2-11-1948 (b) J. F. Bebeck
 (Date received local registrar) (Registrar's signature)

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.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month.....
 year 1948 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.....

Duration

Due to.....

Due to.....

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

Major findings:
 Of operations.....

Of autopsy.....

PHYSICIAN

Underline
 the cause to
 which death
 should be
 charged sta-
 tistically.

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.....

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

SUPPLEMENTARY

MAR 2 1948

6929