

No. 300
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FEDERAL BUREAU OF INVESTIGATION
National Office of Vital Statistics
FILED OCT 18 1948

U.S. DEPARTMENT OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 34695
Registrar's No. 8629

Registration District No. 318

Primary Registration District No. 1003

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

1. PLACE OF DEATH:
(a) County Homer G. Phillip Hosp.
(b) City or town St. Louis Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
HOMER G. PHILLIPS HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community Life _____ (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Mable Gardener Richardson
3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Female 5. Color or race col 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Willie Richardson 6. (c) Age of husband or wife if alive 25 years
7. Birth date of deceased 10-31-1909
(Month) (Day) (Year)

8. AGE: Years 36 Months 10 Days 30 If less than one day _____ hr. _____ min.

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

10. Usual occupation House wife

11. Industry or business _____

12. Name James Jenkins

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

14. Maiden name Reed

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

16. (a) Informant Jessie Reed

(b) Address 2147 1/2 Spruce

17. (a) Burial (b) Date thereof Oct 7 1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park C.

18. (a) Signature of funeral director Wm. F. Home

(b) Address 215 So. Jefferson

19. (a) OCT 4 1948 (b) J. F. Bredek
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State mo. (b) County _____
(c) City or town ST. LOUIS
(If outside city or town limits, write "RURAL")
(d) Street No. 2147 1/2 Spruce
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Sept day 30
year 1948 hour 4:30 minute P. M.
21. I hereby certify that I attended the deceased from _____, 19____, 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 Diabetes Mellitus
Due to _____
Due to 61
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

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) (b) Means of injury _____
23. Signature Patrick E. Taylor (M.D. or other)
Address Deputy Coroner Date signed 10-4-48

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.....

Lynee Hale

Registered Apprentice No. *221*

working under my personal supervision.

Signed *J. H. Hutton*

Licensed Embalmer No. *269A*

P. O. Address *27690thou*

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.