

FILED JAN 31 1949

Registration District No. 2-35

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 4387

State File No. 42580

Registrar's No. 2

1. PLACE OF DEATH:

(a) County Missouri OREGON OREGON  
(b) City or town Alton  
(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 37 years  
years, months or days

3. (a) PRINT

FULL NAME Laura Bell Richardson

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

4. Sex Female 5. Color or race White  
6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife Cy C. Richardson 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Sept. 19 1872  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
76 1 19 hr. \_\_\_\_\_ min.

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

10. Usual occupation Domestic

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Elijah Mullis  
13. Birthplace Unknown  
(City, town, or county) (State or foreign country)  
14. Maiden name Sarah Hollin  
15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant Lloyd Richardson  
(b) Address Alton, Missouri

17. (a) Burial (b) Date thereof 11/9/48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bailey Cem.

18. (a) Signature of funeral director Deland Carter  
(b) Address Thayer, Mo.

19. (a) 1-18-49 (b) ms. w. Johnson  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Oregon 75  
(c) City or town Alton  
(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 Nov. day 8  
year 1948 hour 2 minute 10 A.M.

21. I hereby certify that I attended the deceased from November 1, 1948, to November 6, 1948, that I last saw her alive on Nov. 6, 1948, and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac asthma Duration \_\_\_\_\_

Due to Pneumonia & asthma

Due to \_\_\_\_\_

Other conditions 49  
(Include pregnancy within 3 months of death)

Major findings: Of operations ADDITIONAL  
Of autopsy INTERNAL  
RESECTION 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 Thaddeus Blair (M. D. or other) \_\_\_\_\_  
Address Winnemuth Springs Date signed 12-10-48

RECEIVED 1-25-49  
Director of Health Officer No. 6,  
Dist. of Columbia  
Dist. File Number 14970  
Date Filed 1-26-49

**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 complete the above constitutes grounds for revocation of license.)**  
**If this body is not embalmed, fact should be so stated above.**

**THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH**

State File No. 72K

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 255 PRIMARY REG. DIST. NO. 4387 Registrar's No. 2

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission).	
a. COUNTY <u>Oregon</u>		a. STATE _____ b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Alsea</u>		c. CITY (If outside corporate limits, write RURAL and give township) _____	
c. LENGTH OF STAY (In this place) _____		d. STREET ADDRESS (If rural, give location) _____	
d. FULL NAME OF HOSPITAL OR INSTITUTION _____		e. CITY OR TOWN _____	
<b>3. NAME OF DECEASED</b>		<b>4. DATE OF DEATH</b> (Month) (Day) (Year)	
a. (First) <u>Laura</u>	b. (Middle) <u>B.</u>	c. (Last) <u>Richardson</u> <u>11-28-78</u>	
(Type or Print)			
<b>5. SEX</b> <u>F</u>	<b>6. COLOR OR RACE</b> <u>F</u>	<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED</b> (Specify) <u>wid</u>	<b>8. DATE OF BIRTH</b> <u>9-19-72</u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) _____	<b>10b. KIND OF BUSINESS OR INDUSTRY</b> _____	<b>9. AGE</b> (In years last birthday) _____	
<b>11a. BIRTHPLACE</b> (State or foreign country) _____		<b>11b. CITIZEN OF WHAT COUNTRY?</b> _____	
<b>13a. FATHER'S NAME</b> _____		<b>13b. MOTHER'S MAIDEN NAME</b> _____	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) _____		<b>17. INFORMANT'S SIGNATURE OR NAME</b> _____	
<b>16. SOCIAL SECURITY NO.</b> _____		<b>ADDRESS</b> _____	

<b>18. CAUSE OF DEATH</b> Enter only one cause per line for (a), (b), and (c)		<b>MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>
1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____		DUE TO (b) <u>Bronchial Pneumonia</u>		
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		DUE TO (c) _____		
2. OTHER SIGNIFICANT CONDITIONS (Conditions contributing to the death but not related to the disease or condition causing death.) _____				
<b>19a. DATE OF OPERATION</b> _____		<b>19b. MAJOR FINDINGS OF OPERATION</b> <u>107</u>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>

<b>21a. ACCIDENT SUICIDE HOMICIDE</b> (Specify) _____		<b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		<b>21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)</b> _____	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) _____		<b>21e. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b> _____	

**22. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at \_\_\_\_\_ m., from the causes and on the date stated above.**

<b>23a. SIGNATURE</b> _____ (Degree or title)		<b>23b. ADDRESS</b> _____		<b>23c. DATE SIGNED</b> _____	
<b>24a. BURIAL, CREMATION, REMOVAL</b> (Specify) _____		<b>24b. DATE</b> _____		<b>24c. NAME OF CEMETERY OR CREMATORY</b> _____	
<b>24d. LOCATION</b> (City, town, or county) _____		<b>24e. (State)</b> _____			
<b>DATE REC'D BY LOCAL REG.</b> _____		<b>REGISTRAR'S SIGNATURE</b> _____		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> _____	
				<b>ADDRESS</b> _____	

S-42580