

5. No. 300
10. 48

FILED JUN 9 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

16813

State File No.

86
66

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

BIRTH NO. _____		REG. DIST. NO. <u>274</u>		PRIMARY REG. DIST. NO. <u>3052</u>		Registrar's No. <u>176</u>	
1. PLACE OF DEATH a. COUNTY <u>Pettis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Morgan</u> <u>71</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>Sedalia</u> ()		c. LENGTH OF STAY (In this place) <u>6 hours</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Stover, Mo.</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Bochwell Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>Stover Mo.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>FRANK</u>			b. (Middle) <u>LOOMIS</u>			c. (Last) <u>RICHARDS</u>	
4. DATE OF DEATH (Month) (Day) (Year) <u>May 29 49</u>		5. SEX <u>Male</u> <input checked="" type="checkbox"/>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	
8. DATE OF BIRTH <u>May 29, 1877</u>		9. AGE (In years last birthday) <u>72</u>		10. MONTHS <u>0</u>		11. DAYS <u>0</u>	
12. HOURS <u>0</u>		13. MIN. <u>0</u>		14. SEC. <u>0</u>		15. MIN. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Realstate</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Realstate</u>		11. BIRTHPLACE (State or foreign country) <u>Seattle Washington</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Cornelius Richards</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Wilkerson</u>		14. NAME OF HUSBAND OR WIFE <u>Monte Elie Richards</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs Roland Quinn Lee Summit, Mo.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u> INTERVAL BETWEEN ONSET AND DEATH <u>11 hours</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertension</u> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death <u>Myocarditis</u> 331x 10 years					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 29, 1949</u> , to _____, 19____, that I last saw the deceased alive on <u>May 29, 1949</u> , and that death occurred at <u>7:00 P.</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>R. L. Walter M.D.</u>				23b. ADDRESS <u>Sedalia Mo.</u>		23c. DATE SIGNED <u>5-29-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>June 1 49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Mt Hope Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Kansas City Kansas</u>	
DATE REC'D BY LOCAL REG. <u>5-31-49</u>		REGISTRAR'S SIGNATURE <u>Betty Yeager Deputy</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>H. H. Stevenson</u>		ADDRESS <u>Stover, Mo.</u>	

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 6-8-49

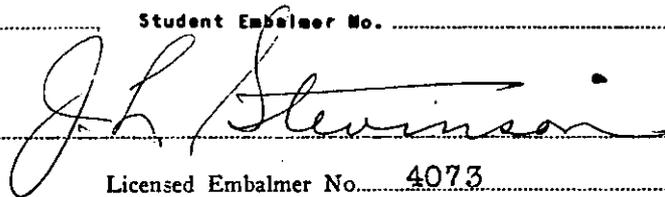
STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Signed _____



Licensed Embalmer No. 4073

Signed _____
Student Embalmer

P. O. Address Stover, Missouri.

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.