

FILED NOV 25 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 36560

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 53 PRIMARY REG. DIST. NO. 3010 Registrar's No. 383

1. PLACE OF DEATH a. COUNTY <u>Cape Girardeau</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>Alexander</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Cape Girardeau</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Tamm</u>	
c. LENGTH OF STAY (In this place) <u>10 days</u>		d. STREET ADDRESS (If rural, give location) _____	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Francis Hospital</u>			

3. NAME OF DECEASED (Type or Print) <u>CLINTON</u>	a. (First) _____	b. (Middle) <u>C.</u>	c. (Last) <u>RICHARDSON</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>November 8, 1949</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April 28, 1885</u>	9. AGE (In years last birthday) <u>64</u>	IF UNDER 1 YEAR Months <u>6</u> Days <u>10</u>	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) <u>Pulaski, Illinois</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>
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13a. FATHER'S NAME <u>Henry Richardson</u>	13b. MOTHER'S MAIDEN NAME <u>Martha Rife</u>	14. NAME OF HUSBAND OR WIFE <u>Gracie Richardson</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>No</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Gracie Richardson</u>	ADDRESS <u>Tamm, Ill.</u>
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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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral apoplexy</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</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) <u>arterio sclerosis</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Hypertrophy prostate</u>			<u>334X</u>

19a. DATE OF OPERATION <u>9-28-49</u>	19b. MAJOR FINDINGS OF OPERATION <u>Prostate Hypertrophy</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
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22. I hereby certify that I attended the deceased from 9-16-1949 to 11-8-1949 that I last saw the deceased alive on Nov. 8, 1949, and that death occurred at 12:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE <u>[Signature]</u> (Degree or title) _____	23b. ADDRESS <u>801 W Broadway</u>	23c. DATE SIGNED <u>11-10-49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Nov. 10, 1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Thistle Wood</u>	24d. LOCATION (City, town, or county) (State) <u>Mounds, Illinois</u>
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DATE REC'D BY LOCAL REG. <u>11-13-1949</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	44	25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>	ADDRESS <u>[Address]</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

16  
4

11  
0  
2

5451 42020

RECEIVED 11-21-49  
District Health Officer No. 4  
District File Number 1149-15  
Date Filed

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.

Student .....  
Student Embalmer

Signed Gen. A. Orsini  
Licensed Embalmer No. Ill. 6495  
P. O. Address Sumner Ill

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.